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Incorporating Expressive Play Techniques within Brief Service:  
Observed Applications within Children's Mental Health

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## **Abstract**

Although models of brief service and play therapy appear to contrast with one another, the underlying tenets of humanistic theory and post-modern social constructivism suggest complimentary combinations within clinical practice. This advanced practicum research report examines my practicum experiences within a children's mental health agency in relation to the compatibility of brief service and expressive play techniques in applied practice. My goals within the practicum were to enhance and strengthen my clinical skillsets as a practitioner through case interventions and supervision. I was also interested in developing a personal practice model regarding the application of expressive play techniques within a brief service delivery approach.

Throughout the report, I will highlight the major themes revealed within my reflective practice and demonstrate the growth of my theoretical knowledge and clinical skillsets throughout the practicum process. The critical analysis of the practicum highlights two distinct observations and insights within my experiences. The first section of analysis includes applications of expressive play techniques within an agency setting, and observations from practical application with families. The second section of analysis will describe themes that emerged through my own self-discovery and the conceptualization of my therapeutic process. Throughout the process of the practicum, I developed an understanding and experience of my therapeutic stance, nurtured my own self-awareness/personal mindfulness practice, and acknowledged the value of combining narrative brief service and play therapy models through experiential learning.

## **Abstrait**

Bien que les modèles de service bref et de thérapie de jeu semblent se contraster les uns avec les autres, les principes sous-jacents de la théorie humaniste et du constructivisme social post-moderne suggèrent des combinaisons complémentaires dans la pratique clinique. Ce rapport de recherche de stage examine mes expériences pratiques dans le cadre d'une agence de santé mentale pour enfants en relation avec la compatibilité d'un service bref et de techniques de jeu expressives dans la pratique appliquée. Mes objectifs au cours du stage ont été d'améliorer et de renforcer mes compétences cliniques en tant que praticien par des interventions et une supervision de cas. J'étais également intéressée à développer un modèle de pratique personnelle concernant l'application de techniques de jeu expressif dans une brève approche de prestation de services.

Tout au long du rapport, je soulignerai les principaux thèmes révélés dans ma pratique réfléchie et démontrerai la croissance de mes connaissances théoriques et de mes compétences cliniques tout au long du processus de stage. L'analyse critique du stage souligne deux observations et des idées distinctes au sein de mes expériences. La première partie de l'analyse comprend les applications des techniques de jeu expressif dans le cadre d'une agence et les observations d'application pratique avec les familles. La deuxième partie de l'analyse décrira les thèmes qui ont émergé à travers ma propre découverte de soi et la conceptualisation de mon processus thérapeutique. Tout au long du processus de stage, j'ai développé une compréhension et une expérience de mon point de vue thérapeutique, j'ai développé ma propre pratique de conscience de soi et de conscience personnelle et j'ai reconnu la valeur de combiner des services de courtoisie narrative et des modèles de thérapie de jeu par apprentissage expérientiel.

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To my parents, for your love, encouragement, faith and lessons that in life we are never presented with dead-ends merely detours: “You raise me up, so I can stand on mountains; You raise me up to walk on stormy seas... You raise me up to more than I can be”-Secret Garden.

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To my fellow classmates; Kelsey, Nicole, Lauren, Kat and Kris for your hugs, humour, tears and friendship. We did it!!: “You say, I’m a dreamer, but I’m not the only ONE. I hope someday you’ll join us, and the world will live as ONE” – The Beatles

“I think to myself, what a wonderful world” – Louis Armstrong

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## **Introduction**

Currently, one in five Canadians live with mental illness but only 25% of the children and adults who require services access them (MHCC, 2012). This is due to a variety of barriers such as the availability of services and which vary greatly across communities, long waitlists, difficult to navigate service pathways, poor system integration, lack of coordination among providers, fragmentation within and across sectors, and ineffective services (Duvall, Young, & Kays-Burden, 2012; MHCC, 2012). The Ministry of Child and Youth Services has sought to alter the structure of children's mental health services in an attempt to contest the barrier of long wait lists for services. When children and families receive long wait times not only are they being deprived of needed services but research has found that when services are available they are less likely to connect (Reid & Brown, 2008). To combat this issue, the Ministry of Child and Youth Services is shifting their framework and service delivery efforts to those of brief service therapy.

Brief therapy treatment sessions can consist of one session to an average of six (Lee, 1997). Research by Talmon (1990) found that the most common number of sessions attended by clients is only one. This demonstrates that therapists need to maximize the impact of the first and possibly only session with a client (CMHO, 2012). All brief service therapies and delivery mechanisms offer therapeutic encounters, instead of assessment at the first session, and then provide a variety of brief service options based on the needs of the family thereby making the most of their time. These services address immediate needs, divert people from waitlists whenever possible, and operate on the premise that "all the time you have is now" (CMHO, 2012, p.15). This model can be seen as a preventative intervention especially for children and youth who present with mild presenting problems and behaviours (Hoagland, 2005). The overarching philosophy is that individuals will receive the amount of service that they need, no

more and no less. This type of intervention may serve as a great alternative for rural communities who are understaffed or agencies that receive high volumes of referrals.

Within the literature that I reviewed, there are several limitations to this approach. From a neuropsychotherapy perspective, the approach is criticized for being a top-down intervention and may prove problematic for individuals presenting with complex histories of trauma (Voelkerer & Rossouw, 2014). As the intervention is a “talk therapy” it may not be the most appropriate for young children whose natural tendency is to express themselves through non-verbal means (Hoagland, 2005; Taylor, 2009). Furthermore, within a literature review by Bond, Woods, Humphrey, Symes, & Green (2013), it was found that, although brief therapy is rapidly increasing in popularity, there is an overall weak foundation of supporting research although the results were found to be promising.

To fulfill partial requirements for the M.S.W degree at Laurentian University I chose to complete my practicum placement within Keystone Child Youth and Family Services, a children’s mental health agency located in Owen Sound, Ontario. Recently, Keystone, assumed the role of Lead Agency for Grey/Bruce as designated by the Province of Ontario. To align with the vision of the Ministry of Child and Youth Services their service structure will be shifting to incorporate a greater emphasis on walk-in and brief service models. Through my training as a play therapy intern through the Canadian Association for Child and Play Therapy, I had a strong interest in the future role of expressive play techniques within this service shift and model. The combination of brief service and expressive play techniques could serve to strengthen the identified limitations of this model.

Play therapy is defined as a dynamic interpersonal relationship between a child and therapist facilitating the development of a safe relationship for the child to fully express and



explore feelings, thoughts, experiences, and behaviours through play (Hoagland, 2003). The child is able to conceptualize, structure, and bring tangible levels of activity to their experiences through spontaneous and self-directed activities. Play gives a child the opportunity to act out situations which are disturbing, conflicting and confusing to her/him, while also providing cathartic release (Hoagland, 2003; Nims 2011). Play therapy is a clinical treatment technique that has been found to be promising when incorporated within clinical work with children and families (Green & Myrick 2014). If these approaches were combined, play therapy could provide the therapeutic presence and brief service models the language by which children and families find their solutions (Nims, 2011). Although I found that a handful of articles discussed brief service expressive play techniques, no articles evaluated the results associated with use of the modality. Instead, the literature discussed practical applications of play therapy techniques, and compatibilities between the brief therapy and play therapy models (Nims, 2007; Nims, 2011; Riley & Malchiodi, 2003; Taylor, 2013; King, 2013).

This advanced practicum research report will describe my practicum experiences within a children's mental health agency in relation to the compatibility of brief service and expressive play techniques. The literature review will examine brief and play therapy approaches. It will also highlight theoretical compatibility between brief and play therapy approaches and recommendations for integration within clinical practice followed by a chapter on the process of the practicum. Next, a discussion of my reflections and critical analysis related to my practicum experience will present major themes demonstrating the growth of my theoretical knowledge and clinical skillsets throughout the practicum process. This report will then conclude with observations regarding implications for social work practice in general.

## **Chapter 1 – Literature Review**

This literature review examines two models of brief service therapy: solution focused and narrative therapy. In addition, an overview of play therapy and two approaches in particular will also be explored: sandtray and art-making. The review will highlight theoretical compatibility between brief and play therapy approaches and present recommendations for integration within clinical practice. The search strategy for the literature review utilized the Laurentian University PsyINFO, Social Work Abstracts and Social Services Abstracts online databases, Google Scholar, and the APA PsycNET database. The following key words were used: solution-focused brief therapy, narrative brief service therapy, single session, narrative, expressive play therapy, sand play, sand tray, play therapy, art therapy, limitations, neuropsychotherapy, play scaling, systematic review, solution oriented, client-centered, child engagement, therapist perceptions.

### **Solution Focused and Narrative Therapy**

Solution focused and narrative therapies are based on the theoretical principles of social constructivism (Haire, 2009; Maxsom, 2001; Lee, 1997). These principles are complimentary to a post-modern interpretation of psychotherapy. This theoretical framework diverts from the family systems perspective by viewing an individual's reality within a cultural, social and relational setting as opposed to only being confined within the "interpersonal interactions of the family environment" (McCluckie & Rowbotham, 2013, p. 117; Faoite, 2011). Problems and solutions are not objective realities but are subjective to a person's construction and interpretation. Accordingly, therapy is viewed as a process in which the therapist and client co-construct new beneficial systems or frames that are conducive to problem resolution (Lee, 1997). The goal of therapy is "not to replace a story with another but to enable the client to participate in the continuous process of creating and transforming meaning" (Gergen, 1996, p. 215)

Social constructivists deviate from pathologizing and instead approaches ‘mental problems’ from a strengths and competency-based lens that assumes clients have the innate ability to solve their own problems and possess the resources necessary for problem solving (Haire, 2009; Faoite, 2011). For the therapist, this means that the traditional position of “expert” is abandoned. Instead the client becomes an expert of their own lived experience. The therapist’s role is as a “co-discoverer, helping to direct conversation so that these resources are discovered in a collaborative approach” (Young, 2016, p. 2). The aim is to enrich the client’s understanding of the interpretation rather than imposing an expert opinion and shutting down understanding (Cattanach, 2006).

As a clinician, this model presents the challenge of adopting a position of openness and uncertainty, and in practice this means allowing questions to emerge in the moment with a client that do not interrupt the flow of the story or the child’s play (Faoite, 2011). By allowing oneself to be completely present with a client in this way, one is not being informed by theoretical knowledge but rather the “local knowledge” provided by the client (Faoite, 2011, p. 354). This philosophy challenges the clinician to increase “space” in the therapeutic process. This requires the clinician to be “self observant within the therapeutic system by paying attention to his or her own values and how these can influence the process of therapy” (Maxsom, 2008, p. 21).

Although based in the same theoretical foundation, the distinct methods and philosophies of each model will now be examined.

### **Solution Focused Brief Service Therapy**

Solution focused therapy is credited as being developed by de Shazer and Berg in the 1980’s (Bannick, 2007). It is a competency-based model that focuses on finding solutions and gives little attention to defining or understanding the roots of presenting problems (Trepper,

2010; Lee, 1997). There are three basic components to the client/therapist relationship within this model. The first is developing a strong working alliance that is both respectful and collaborative. This component is of utmost importance within all forms of therapy and is considered one of the most defining features of successful treatment (Siegel, 2006). The second component is finding the innate strengths and resources present within the individual. Throughout the process this would include finding times of exception from their problem, their existing strengths, solutions, and then helping the individual find new uses for these resources and abilities (Hoagland, 2005). The last component is the co-creation of achievable goals. However, instead of asking families to make large drastic changes, the focus is on small changes and solutions to specific problems (Hoagland, 2005).

Once well-formulated goals have been made with the client, the therapist utilizes the following techniques: “(a) use of the miracle question, (b) explore whether change is currently taking place, (c) identify what it will take to marshal or sustain change, and (d) monitor the client’s change until he or she feels they can maintain it” (Tyson, 2004, p. 215). The therapist allows the client to rate their own progress and effectiveness at attaining solutions by using a scaling technique. This is a numerical assessment. A one to ten value is used to identify and clarify improvements and provides the therapist with a visual aid to how the client interprets and experiences their problems and solutions (Haire, 2009).

Some of the advantageous reasons for using this model are that it is a relatively safe approach as it is a client-centered and competency-based model (G. Lubimiv, personal communication, August 3, 2016). The inherent safety of the model makes it an excellent starting point for all clients seeking clinical intervention and moving to other approaches if SFBT is not effective (G. Lubimiv, personal communication, August 3, 2016). Although there are advantages

to the safety of the approach, numerous limitations of this approach have been cited. Bond et al. (2013) found that, within their study, a literature review of all solution focused quantitative and qualitative studies conducted between 1990-2010, 38 studies were cited but only five were found to be methodologically sound. This study highlighted that the overall literature supporting this approach appears to yield promising results but is methodologically weak (Bond et al., 2013). Much of the research is descriptive in nature with very few experimental designs. Although case studies have provided proof of effectiveness with this approach there have been few studies that have focused on the sustainability and long-term effects of solution focused methods (Tyson, 2004). Though the current research methodology is weak, clinicians should not be deterred from using this model as it is a good fit with children as they naturally think about the future and are happier to focus to what they are doing right than wrong (King, 2013).

### **Narrative Brief Service Therapy**

Narrative therapy and its philosophies were pioneered by Michael White and David Epston in the 1980's (Etchison & Kleist, 2000). White's work is important as it implies social construction thinking to understanding the problems and position of clients and families in relation to problems in therapy. White coined the term 'problem saturated' narratives as he noticed how families came to therapy speaking about how the problem dominated the lives of the family (Young, 2016, p. 4). Within this therapy the therapist assumes that people's actions are guided by culturally diverse meanings and stories that they continuously construct about themselves. The person is understood as being situated within a culture and a social setting, and in relation to other persons. Stories become the means to express ourselves and these relationships. Our view of self is not fixed but rather is constantly changing based on the interactions with others and our environment (Faoite, 2011).

White and Epston (1990) believed that clients come to therapy because the dominant story that they use to view their experiences is no longer effective (Young, 2016). Therapy then helps the individual to shift from the old dominant story to a new subjugated story by externalizing the problem. This creates a counter-language that objectifies the problems, the suffering and the difficulties people get into during their lives instead of pathologizing an individual (Lundby, 2014; Maxsom, 2001). The externalization technique helps to relieve clients from self-blame, guilt or shame from possessing these problems and helps them to discover the strength they possess over the problem (Maxsom, 2001).

Every aspect and every practice in narrative therapy is about 'double' or multi-storied experiences of life and identity (Lundby, 2014, p. 31). The stories about our identity that form when problems and suffering enter our lives tend to become very thin and problem saturated. Narrative therapists seek to contribute to 'rich' or 'thick' tellings and re-tellings of people's identity stories. As humans, we look for meaning and as we try to understand how things are linked together; it is the stories that we create that provide this meaning (Lundby, 2014, p. 33). Thin stories lack detail while thick stories are inscribed with meaning and find linkages between the stories of people's lives and their cherished beliefs, purposes, desires, and commitments (Maxsom, 2001). Individuals create stories about experiences that are special and unique, and these represent aspects of an individual's identity (Lundby, 2014).

Conversations within sessions are based on a scaffolding approach that works from the "known and familiar" to a "possible to know" plane (Young, 2016, p. 8). Scaffolding allows clients to distance themselves from aspects of problems so that they can develop new conceptions of self, identity, problems, and resources. Distance and increased mastery invite clients to gradually exercise personal agency (Young, 2016). Using this approach allows the

therapist to begin to deconstruct the problem to begin to co-discover and develop subordinate storylines: “Deconstructive listening places an emphasis on the therapeutic process being conversational, not technical” (Maxsom, 2001, p. 20). By harnessing the power of deconstructing questions, the client may begin to understand that there are alternatives to the stories they are presenting. For example, what values motivate a client to respond in a certain way and who are the important individuals that may have influenced these values? Please refer to Appendix A for a scaffolding conversations model. In summary, the brief therapy approaches discussed apply unique techniques to a post-modern social constructionist approach to psychotherapy. Next, I will discuss play therapy and the experiential models that I will be incorporating within my placement.

### **Experiential Methods of Practice**

#### **Play Therapy**

Play therapy is defined by the Association for Play Therapy (2016) as: “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (p. 1). Some examples of predominant theoretical play therapy models include Jungian, Adlerian, Gestalt, Child-Centered, Filial, and eclectic approaches (Carmichael, 2006). Over time, play therapy has grown as a model beyond the simple use of toys in a playroom to include most of the expressive forms of therapy: “art, music, dance, drama, movement, poetry and storytelling” (Carmichael, 2006, p. 2). A play therapist may borrow techniques from other expressive forms of therapy to allow flexibility in the mediums offered to a child to express themselves. However, a play therapist receives specialized training as a play therapist and is not considered an art, music, or drama therapist (Carmichael, 2006).

Through play and play-based interventions, children can communicate nonverbally, symbolically, and in an action-oriented manner. Erikson (1950) maintained that the play of the children is “the infantile form of the human ability to deal with experience by creating model situations and to master reality by experiment and planning” (p. 222). Play is an essential element for the holistic development for children, allowing them to explore and make sense of their world, welcome nurturing behaviours, develop self-regulation, creativity, social skills, and provides a means to communicate internal states (Wheeler & Dillman, 2016; Hong & Mason, 2016, Kestly, 2016). Schaefer (1999) identified 25 therapeutic factors that are positively affected within play therapy. Some of these include but are not limited to: “abreaction, access to the unconscious, self-expression, catharsis, attachment and relationship enhancement, reality testing, and counterconditioning of negative affect” (Shaefer & Athens, 2011, p. 5-11) In service to involuntary clients, play draws children and adolescents into a working alliance and can help to lower resistance.

Play is a natural form of learning and communication within childhood. Within our mammalian brain lies an “instinctual action apparatus” that contains specific circuitry dedicated to play, which is a testament that this is an instinct (Kestly, 2016, p. 13). Play is fun, enjoyable, and elicits positive emotions that in themselves serve an important function. Studies from positive psychology have shown that positive emotions help us to broaden our activities encouraging pursuit of a wider range of thoughts and actions (e.g., play, explore, savor, and integrate). This has been found to be opposite in regards to negative emotions, which narrow an individuals’ reactions by eliciting specific action tendencies (e.g., attack or flee) (Kestly, 2016). Emerging interpersonal neurobiology (IPNB) research confirms that play experiences positively influence neuronal function and brain structure (Wheeler & Dillman, 2016; Hong & Mason,



2016). Badenoch and Kestly (2015) have stated that emerging principles of IPNB support play therapy “as an optimal means for children to find their way back to a healthy developmental path” (p. 525).

When a child’s play environment is safe, they may express themselves, activating the nervous system, and providing opportunity for the development of deep and meaningful relationships (Cozolino, 2010b). This also presents as an opportunity for implicit learning – when unconscious early memories may emerge within the play (Kestly, 2016). Implicit memories are created outside of awareness between two associated stimuli. This is the memory involved in the creation of associations between sensory stimuli and traumatic events. These memories can then be processed and move from unconscious to conscious representations such as symbolic storytelling with puppets. The play therapist can then assist the child in finding verbal language that bridges implicit and explicit memories to develop an understanding of their autobiographical memories (Wheeler & Dillman, 2016). In individuals who have experienced implicit trauma, no amount of verbal explanation will change their implicit memories. Rather, for this type of memory to be altered, the same sensory-based neural systems involved in the creation of the memory must be activated, making a strong case for the use of play in the activation and processing of implicit learning (Wheeler & Dillman, 2016; Hong & Mason, 2016). There is also strong evidence to incorporate play techniques within trauma treatment: “Evidence suggests that trauma memories are imbedded in the right hemisphere of the brain, and thus that interventions facilitating access to, and activity in, the right side of the brain may be indicated. The right hemisphere of the brain is most receptive to nonverbal strategies that utilize symbolic language, creativity and pretend play” (Gill, 2006, p. 68).

Within a general play therapy model there are three stages of treatment. Stage one revolves around rapport building (Nash & Schaefer, 2011). This stage is present within most clinical interventions. Stage two is termed ‘working through’ in which themes become apparent in the play and offer a glimpse into the world of the child/youth (Nash & Schaefer, 2011, p. 9). Some examples of themes may be shame, grief and loss, anxiety, and depression. This stage is where the therapeutic changes occur and the process employed within this stage will vary based on the theoretical orientation of the therapist. (Nash & Schaefer, 2011) The third stage is termination where the child/youth and family have resolved the referred issues and make plans for sustaining the change moving forward (Nash & Schaefer, 2011)

I have completed the specialized training offered through the Canadian Association of Child and Play Therapy (CACPT) and my membership denotes me as a Play Therapy Intern. Within the MSW practicum placement, I incorporated play therapy techniques of sand play and art within my work with children and families. I have chosen these modalities because I have been trained by CACPT to use them within a play therapy model. Additionally, the costs associated with both techniques are inexpensive and could easily be incorporated within an agency setting.

### **Sandtray**

Sandtray is a primarily nonverbal method in that the therapeutic work is done within the sand using carefully selected materials such as figurines, miniatures, and objects. The materials allow clients to portray what is occurring within their world in a way that is safe and non-threatening (Taylor, 2009). Individuals who struggle to express themselves verbally also have an opportunity to use the sand tray and figurines as a means of communication. The use of sand tray provides unique opportunities for problem solving in that individuals can obtain new

perspectives of a situation from a “three-dimensional field” (Taylor, 2009, p. 56). Use of a sand tray and figures may also appear less threatening to some individuals as it does not require any skill which may be required in other expressive techniques such as drawing or painting. The sand itself acts as a sensory exercise and individuals may find the textures to be relaxing. Within this modality there are two predominant approaches that offer distinctive views on the sandtray process; Sandplay and Sandtray-Worldplay.

Sandplay, a Jungian modality, was pioneered by Dora Kalff in the 1950's. Kalff developed sandplay from Lowenfeld's Worldplay model. Within this approach, the therapist provides the client with a “safe and protected space” that allows for images of reconciliation and wholeness and reestablishes the connection between ego and self. The therapist interprets the play and each object is then a symbolic representation of something that is occurring for the client. The therapist remains silent for the session until its end. The stance of the therapist then becomes the holder of scientific expertise and aligns with a more traditionalist approach to treatment.

In the 1980's, Gisela DeDomenico developed sandtray-worldplay, a postmodern approach to Sandplay work. Informed by her phenomenological research, her focus became that of “fully experiencing the process, the products of the play and the healing ‘meaning-making’ that occurs during the different phases of the Sandplay process” (cited in Labovitz Boik & Goodwin, 2000, p. 8). Her model moved away from a psychoanalytic approach of focusing on the unconscious and instead chose to focus on aspects of consciousness. Aligning with a postmodern approach, she believed that the role of the therapist should be one a “co-explorer” and as a mediator. The therapist then takes on a more active role in facilitating reflection on the part of the client in their narrative construction processing thus allowing strengths, successes,

and preferred identify to be emphasized (Gallerani & Dybicz, 2011). Some of the statistically significant benefits of using sandtray with children and youth include reducing aggressive behaviors (Momeni, K., & Kahrizi, S., 2015), separation anxiety (Nasab & Alipour, 2015), depression (Maree, J. G., Ebersöhn, L., & de Villiers, D. A., 2012), and trauma (Doheny, 2015).

### **Art-Making**

Expression through art can take a variety of forms including writing, painting, drawing, and sculpting. Using art therapeutically is a recognized form of treatment and can be used within a play-based approach (Haire, 2009). It is based on the idea that the creative process in itself is healing and acts as a nonverbal form of communication between thoughts and feelings (Vick, 2003). Tyson notes five benefits of arts and creative treatment modalities:

“(a) calls attention to the process of creative expression...and the unique nature of the strategies employed in this process, (b) provides experiences that the client can use to assist them with better understanding themselves and others, (c) helps clients to develop new strategies to deal with their problems, (d) provides a vehicle to link together experiences of their past, present and future, (e) enables clients to express the strengths of their cultural background and heritage” (Tyson, 2004, p. 216)

Art is an excellent modality to help externalize the problem from the client. The distancing creates a safe therapeutic environment for them to contain difficult emotions and begin deconstructing and processing their problems or traumas (Haire, 2009). Aside from being considered an innate human tendency, art therapy is powerful as it is considered a “mind-body intervention” meaning that it facilitates the mind’s ability to influence bodily functions and symptoms (Malchiodi, 2003, p. 17). In a study conducted by Archibald and Dewar (2010), they

sought to investigate what happened when creative arts (art, drama, storytelling, dance) were incorporated into healing programs for First Nations Peoples. The themes that were revealed within their research are a testament to the therapeutic properties of these interventions. The themes were as follows: three interconnected concepts are presented in regards to the connections between creative arts and Indigenous culture, (1) Creative arts as Healing - Creative activities are viewed as having healing benefits in themselves whether art forms used were traditional or western, (2) Creative arts in Healing- Including creative arts in trauma recovery and therapeutic healing programs; arts are viewed as deepening, supporting and enhancing the healing process, (3) Holistic Healing includes Creative Arts – situated creative arts within the frame of culture, spirituality and holistic healing (Archibald & Dewar, 2010, p. 6) (please see Appendix B for model). This model illustrates the inherent healing properties of art in itself as well as how this is enhanced when incorporated within a therapeutic intervention.

### **Compatibilities between Brief Therapy and Play Therapy Models**

Within brief therapy and play therapy there are shared underlying principles that provide evidence of complimentary theoretical applications between the two approaches. For example, they empower clients to be masters of their own lives and capitalize on their inherent strengths and resources (G. Lubimiv, personal communication, August 3, 2016). There is a focus on the healing of the self and not techniques (Taylor, 2009), and both externalize the problem from the individual (Riley & Malchiodi, 2003). Nims (2007) stated that play therapy can help to develop the therapeutic presence while solution focused and narrative techniques provide the language, which furthers the child/youth's ability to articulate their goals. Furthermore, not only does play therapy possess similar underlying philosophies, but it also presents several complimentary

techniques that serve to strengthen existing brief therapy principles. Throughout the remainder of this chapter, the combination of brief service and play therapy will be termed BSPT.

### **Engagement**

Between the two models there is a strong focus on the interpersonal processes involved in healing the self and less emphasis is placed on the actual techniques employed. For instance, both models do not prescribe a standardized approach to therapy such as cognitive behavioural therapy. The reflexivity of the therapist to attune to the needs of the client in the present moment becomes the focus as healing and is based on relational interactions of the client with themselves and others. A definition of healing through this lens is termed as: “healing involves inner, relational, and heart processes” (Taylor, 2009, p. 58). Creating art or telling stories results in a greater understanding and appreciation of each client’s culture, reflecting the soul or inner being of all persons (Haire, 2005). Experiential activities often result in a higher level of therapeutic engagement because the approach is fun, tangible, and developmentally appropriate (King, 2013). Tyson and Balfour (2004) found within their study that youth naturally turned to the arts for comfort and healing in times of crisis. By supporting youth to do this, the therapist can affirm the value and worth of clients as self-directed individuals (Tyson and Balfour, 2004).

Research has found that when art-making is followed by verbal processing within a brief service model, a client’s comfort increased through art-making even when verbally discussing emotional material related to the problem (Haire, 2009). Expressive therapies can operationalize specific brief service techniques allowing for multi-sensory engagement that includes “visual and motor modalities” (Matto, Corcoran, & Fassler, 2003, p. 265).

Individuals may also feel more comfortable exploring emotional material related to problem areas when the material is “revealed” through the art-making process rather than

“exposed” by direct verbal deconstruction (Matto et al., 2003, p. 267) Therefore, there is a strong focus on therapeutic rapport and engagement in a time sensitive environment. This “verbal processing protocol” has been outlined by Matto et al (2003) in four stages: “(1) Critical engagement, (2) initial reactions, (3) relational attributes, and (4) constructing change opportunities” (p. 267). These protocols can be used to enrich the art and play activity within a brief model. These stages are outlined in Table 1.1 below:

<b>Table 1.1</b>	<b>Description</b>	<b>Example</b>
Step 1: Critical engagement	Invites the client into formal properties analysis and discuss the following properties of the artwork: colours used, placement of objects on the page, and the type and extent of the art medium used	<ul style="list-style-type: none"> <li>- What would the title of your picture?</li> <li>- Tell me about your picture?</li> <li>- What does this element represent?</li> </ul>
Step 2: Initial Reactions	Subjective and reactive in nature, allowing for the full expression of feelings without constraints or interpretation. The therapist helps the client begin to explore associated feelings while being cognizant of their own feelings and reactions to the imagery.	<ul style="list-style-type: none"> <li>- What are the objects/people feeling?</li> <li>- How do these objects/people wish they could feel?</li> <li>- Where is the strength and hope coming from?</li> </ul>
Step 3: Relational Attributes	The therapist looks for relational elements by exploring the following themes and patterns within the picture	<ul style="list-style-type: none"> <li>- How does this picture relate to you now?</li> </ul>

	a) Object-to-object b) To self c) To others d) To life circumstances e) To temporal elements	- Who in your life right now needs to bear witness to your art? - Where is the loudest part of your drawing? What is it saying? Who is listening? Who would you like to be listening?
Step 4: Constructing Change Opportunities	Following the objective, subjective and relational discussions there is a shift towards a solution-focused analysis of change opportunities. This protocol provides a constructionist perspective of eliciting engagement with an art activity and omitting therapist bias and interpretation	- What would you like to be different about your drawing? - What parts of the picture do you need to “let go” of? - What would a picture in response to this look like?
Taken from Matto et al. 2003, p. 267		

Research completed by Walters and Willis (2014) sought to investigate the correlational relationship between talk only techniques, play-based activities (art, board games, charades, games made up by family) and child participation (measured by child talk) in single-family sessions. Their results revealed that time in play-based activities was not only a significant predictor of child talk time but it was also the strongest predictor among a set of variables to



influence child talk. The data also highlighted that the longer time spent in strictly talk-based therapy was directly associated with less child involvement (child talk).

### **Treatment Outside of Counselling**

The research completed by Walters and Willis (2014) also provided promising support for the following hypotheses “that play based techniques in family therapy can “(a) facilitate the development of a stronger emotional bond or therapeutic relationship between young children and the therapist (Schaefer & Drewes, 2011), and (b) increase positive affect among family therapy participants” (Gil, 2004). (Walters & Willis, 2004, p. 298). These findings also support that in supporting the family to play together the therapist is also helping to promote cohesion among members (Walters & Willis, 2014).

Thus, two arguments can be brought forward: (1) that families including children need to play an important role in treatment, and (2) that these techniques can be used as an adjunct to therapy outside of session. Teaching skillsets in solution focused and narrative techniques to parents can provide the family with lifelong strategies for working through everyday challenges (Hoagland, 2005). Moreover, this can be done through novel means: “Family play therapy moves treatment from the intellectual, cerebral, abstract world familiar to adults, to the world of imagination, spontaneity, metaphor, and creativity that is familiar to children” (Lowenstein & Sprunk, 2010, p. 1). Leblanc and Ritchie (2001), Bratton et al. (2005), and Lin and Bratton (2015) concluded after meta-analyses of play therapy research that there was statistically significant moderate treatment effect size between studies with full parent involvement and studies with partial to no parent involvement. These findings provide support to include families within treatment. Families may also be engulfed by the problem and may have forgotten how to enjoy one another. Engaging in play can help to strengthen the bond between members. The

therapist can view their role as helping to “honor the inherent parent-child bond, restore it and help bridge the differences between parent and child” (Hoagland, 2005, p. 50).

### **Externalizing the Problem**

Externalizing the problem occurs when the client creates a form of artwork or world that separates the problem from themselves. Externalizing involves making a linguistic distinction between the presenting problem and the person in which the problem behaviours are personified (Matto et al., 2003). The purpose is to free the person from the belief that the problem is a fixed and inherent quality. The expressive activity thus becomes a container for the problem and emotions surrounding the problem creating a safe space for difficult therapeutic work to be contained (Haire, 2009). The client is also able to take a step back and view their situation with a whole new perspective through the three or two-dimensional creation produced through the use of an expressive technique (Taylor, 2009). This can be useful in generating new solutions to old problems or engrained behaviours.

### **Goal-Setting in Treatment**

In goal setting, some children may not be capable of understanding the concept of scaling, and sand tray and miniatures can become a visual aid for more complex and difficult to understand concepts as well as an action picture of what happens in relationships when change occurs (King, 2013; Taylor, 2009). Additionally, clients will also be able to see their progress visually by recalling the succession of artwork and sand trays throughout the course of treatment, providing a valuable therapeutic tool (Tyson, 2004).

Art-making techniques are compatible with solution-focused brief approaches as the process of creating images tends to accelerate the emergence of thoughts and recall of memories and details (Matto et al., 2003). The techniques can also be used to portray what will happen

within relationships when the change occurs and helps the client to be future-goal oriented (Taylor, 2009). If clients are having a difficult time identifying their goals or personal strengths, expressive techniques can be used to identify a client's personal strengths as well as challenges that may require attention within treatment (Taylor, 2009).

### **Evidence from Interpersonal Neurobiology**

Evidence suggests that trauma memories are embedded in the right hemisphere in the brain (Klorer, 2008). It has been argued that the right hemisphere of the brain is most receptive to nonverbal strategies that utilize symbolic language, creativity, and pretend play (Gil, 2006, p. 139). "Storytelling weaves together sensations, feelings, thoughts and actions together in ways that organize both one's internal and external worlds...the combination of a goal orientated linear storyline with verbal and nonverbal expressions of emotion activates and utilizes processing of both left and right hemispheres and cortical and subcortical processing" (Cozolino, 2002, p. 34-36).

From a neurobiological viewpoint, the brief therapy models are a predominantly top-down approach that assumes that individuals have a functioning pre-frontal cortex that is accessible even when limbic areas of the brain are over activated (Voelkerer & Rossouw, 2014). If the emotional networks of the lower brain are not addressed it could threaten the success of treatment. Play therapy techniques are a predominantly bottom-up approach. The combination of the two approaches could offer a more holistic neurobiological model of treatment. Matto et al., (2003) stipulated that by combining a goal-oriented storyline with verbal (SFBT) and nonverbal expressions of emotion (PT) there is activation and processing in both left and right hemispheres, and cortical and subcortical processing. These processes are present within expressive and art

techniques and can result in possible “biological and psychosocial change” (Matto et al., 2003, p. 266).

### **BFPT and Social Work Practice**

As a profession, social workers must be able to work within a variety of theoretical frameworks, and social conditions brought forth by their clients. As reviewed above, art and play based methods have been found to bring enriching elements to therapeutic applications. Despite the existent literature in these areas, social work seems to be stuck in a talk-only approach (Walton, 2012). What barriers are presenting resistance for social workers to embrace these approaches within their practice? Research completed by Sanders (2013) found that a therapist’s anxiety around their own creativity influenced their decision to use art as a therapeutic tool or even to introduce arts-based methods as a coping tool for clients. This brings into question whether personality characteristics of therapists increase the likelihood of incorporating these approaches. These methods embrace an approach that values imagination, feeling, experience and intuition, and this in turn must be shared by the social worker (Coholic, 2012). At an individual level, research completed by Solt (2003) found that when comparing non-play therapy (NP) and play therapy students (PT), there were statistically significant differences in the personality traits of extraversion (NP high, PT average) as well as a more favourable attitude toward children (PT). This presents an interesting gap in the literature in how a therapist’s self-view impacts therapeutic choices (Solt, 2003; Sanders, 2013).

Another barrier that was identified within the literature was lack of formal training and exposure to the expressive methods (Sanders, 2013). However, formal training is not required to make art. Art should instead be viewed as a form of “personal practice informed by cultural and social attachments, folkways, personal experience and temperament” (Moxley, 2015, p. 35). The

same could be said for play as this is a natural occurrence of human condition (Kestly, 2016). But a distinction should be made between play and arts-based methods, and play and art therapy. Social workers were less likely to acknowledge that they used art therapy but were able to state that they did incorporate some art in their therapy due to insecurity from lack of formal training (Sanders, 2013). However, Sanders (2013) found that the more exposure individuals had to these methods, whether it be through formal training or conversations with colleagues, the more likely they would incorporate these concepts into therapy. Thus, social workers would benefit from shifting their conceptions of play and arts-based methods as a separate theoretical framework and approach, and instead embrace the methods as tools to supplement their current approaches with children and families (D. Coholic personal conversation, Feb. 27, 2017).

As Keystone, has been designated a lead agency for mental health services, one example of how expressive play and arts-based methods could be utilized is through community engagement. Research concerning the integration of the arts and community engagement have found that these practices can lend a more adequate and accurate account of peoples lived experiences (Sinding, Warren, & Paton, 2014); empower the perspectives of oppressed individuals (Moxley & Carrigan, 2014); and engage wider communities as it illuminates the consequences of social issues for individuals (Moxley, Carrigan, & Washington, 2012). An organization such as Keystone could strengthen existing agency initiatives such as program assessment and development, family engagement or advocacy with art and expressive techniques as they have been found to engage clients, and strengthen client voices and experiences.

### **Future Research**

Although there are many possible benefits to a brief play therapy model, research into brief therapy models and play therapy techniques are scarce and are also limited to case studies

and subjective reporting for both adult and child populations (Haire, 2009). Though studies exist that have incorporated the two models such as postmodern Sandplay, narrative play therapy, solution focused play therapy, and solution focused art therapy, substantial literature does not exist on any of these models at present.

All the research gathered in regards to the effectiveness of play therapy consisted of at least three or more sessions. Literature regarding the effectiveness of play therapy techniques within a walk-in, single session, or under three sessions was not found while conducting the literature review. Reflections within my practicum that seek to accomplish this could be useful to informing how and if the proposed compatibilities fit within practice as well as how the model can be expanded to encompass additional aspects of social work practice.

Although strong methodological evidence for both brief and play therapy is slowly emerging, the lack of a structured model for intervention makes it difficult to examine its effectiveness. Process-oriented studies are more conducive to these models of intervention. However, research is lacking in regards to process-oriented studies of play therapy that investigate the mediators or specific therapeutic factors that produce desired change for clients (Drewes & Schaefer, 2016). Process outcome correlational studies help to illuminate the specific components of therapy that promote healing and growth (Willis & Walter, 2014, p. 287).

In the next chapter I will be discussing the advanced practicum environment, the agreement with the agency, learning objectives, and the critical role of personal reflexivity and reflective practice. I will offer a broad overview of my intentions behind pursuing an advanced practicum, and how the experience nurtured clinical skillsets and personal growth.

## **Chapter 2 – The Description and Process of the Practicum**

In accordance with the partial requirements of the Laurentian University, Master of Social Work program, I completed the Advanced Practicum (SWRK 6024) from September 12<sup>th</sup>, 2016 to February 8<sup>th</sup>, 2017. The practicum was completed at Keystone Child Youth and Family Services, a children's mental health agency serving Grey and Bruce Counties. Within this Chapter, I will be describing the practicum environment including agreements made with the organization and pertinent details of the experience such as supervision received, my learning objectives, the theoretical lens that guided my learning as well as the critical role of reflexivity and reflective practice.

### **Description of the Advanced Practicum Environment**

My practicum placement was completed within Keystone Child, Youth and Family Services, located in Owen Sound, Ontario. Keystone offers a variety of mental health services to the children and youth of Grey and Bruce County, ages 0-17 years, including individual and family counselling, risk assessment, psychoeducational groups, tele psychiatry, and residential day treatment programs (Keystone, 2016). The geographical service area provides unique challenges as it is not only expansive but also predominantly rural. Additionally, there are sub-populations within this area that require specialized services, for example, Cape Croker First Nation, Saugeen First Nation, Metis peoples, and Canadian Forces members and veterans. Individuals who seek services may access them within school, agency, home, and community settings.

In 2016, Keystone was named the lead agency by the Ministry of Child and Youth Services for Grey and Bruce County. This designation is an effort by the Ministry to create a funding model that creates more harmony amongst community level mental health services:

“A new leadership model that brings structure to the system and facilitates collaboration, communication, and respect between lead agencies, sub-contracted agencies, regional offices, and government...Lead agencies and sub-contracted agencies will work together to provide the highest quality of care and share responsibility for meeting the mental health needs of the children and youth living in their communities” (MCYS, 2013, p. 3)

Keystone’s model for clinical services is consistent with the mandate of the Ministry of Child and Youth Services in their shift in services to embrace brief service therapy for timely, accessible services for individuals seeking mental health treatment. While completing my placement, the Agency was developing a new process for individuals to access services. A walk-in clinic was being designed to reduce the waitlist to nil as well as give individuals more timely access to services. Individuals may choose to terminate after one session or move into clinic services. Within clinic, individuals receive three to four sessions and if individuals feel that they require additional counseling the case is moved into a longer-term intervention. Prior to beginning my placement, I was unaware that this shift in service would be occurring, thus my learning goals also shifted within the course of the placement to become more aligned with my learning environment.

### **Agreements with the Organization**

Ms. Suzanne Lacelle, Field Coordinator for Laurentian University, provided the appropriate forms to Keystone administration. As per agency requirements, the mandatory paperwork including criminal reference checks for working with vulnerable populations were completed.

Within the first week of placement, I received orientation to agency mandates and ethical procedures. While at Keystone, I had access to client files, confidential information and all other



resources that full-time staff are authorized to access. I received training in the data management system used by the agency called EMHware and learned agency expectations in regards to case notes and documentation. As I received the same privileges afforded to employees of Keystone, I was cognizant of the sensitivity around issues of confidentiality and took extra care to adhere to the same regulations, responsibilities, and ethics that are expected of all agency staff.

### **Supervision**

Ms. Michelle Scobie, MSW, holds the role of clinical supervisor at Keystone and provided supervision during the duration of my placement. Also, an agreement was reached that I would receive regular clinical supervision from Ms. Lori Lanktree, an MSW frontline worker. This was more conducive to my learning as Ms. Scobie was not carrying a caseload and Ms. Lanktree's schedule permitted her to be more accessible to me.

Supervision with Ms. Lanktree was ongoing, occurring almost daily. Lori and I would sit in together on sessions and afterwards discussed observations, clinical wonderings, how to approach future sessions, and opportunities for reflexivity. This supervision was invaluable as it gave true frontline experience and highlighted the importance of collaboration. Also, because it was received in an environment of mutual respect and trust, the process enhanced my growth as a student practitioner. Supervision with Ms. Scobie, was more formal and scheduled twice a month to discuss my progress within the practicum, ensure opportunities to meet my learning objectives were being provided, review EMHware data, and receive clinical supervision as required.

In the early weeks of my placement I shadowed other counsellors in sessions as well as community workers who completed assessments and parent psychoeducation within home and school environments. I observed professionals with strengths in specific orientations such as

solution-focused, cognitive behavioural, and eclectic approaches, and could see how strategies were translated into practice with clients. Once I became more comfortable in the role I transitioned to co-therapist and then acquired my own caseload with referrals for first-time appointments. Once I had acquired my own caseload I could engage in the counselling process from beginning to termination, and experiment in incorporating expressive arts within sessions.

Dr. Diana Coholic was my designated first reader and Dr. Leigh MacEwan was my second reader during the completion of my practicum. Throughout the practicum, we connected through e-mail, telephone, and Skype. As my practicum was completed at a significant distance from Sudbury, this mode of supervision was most appropriate. The readers provided supervision as needed to ensure that learning goals and objectives were being met, the practicum environment was conducive to regulations stated by Laurentian University, and oversaw the progress of the thesis component. Dr. Coholic through her own research interests is an expert in the benefits of incorporating creative arts within treatment of children and youth, and this knowledge was invaluable for the reflexivity analysis and writing process.

### **Training Plan**

The purpose of the practicum was to hone and develop clinical skillsets and theoretical knowledge in brief therapy approaches and reflect on how play and expressive methods may be complimentary (or not) to these approaches in an agency setting. My learning goals were:

- 1) Develop strong clinical skillsets in regards to assessment and standardized forms required by the hosting agency,
- 2) Develop a strong theoretical and practical understanding of the underlying principles of brief service therapy,

- 3) Enhance and strengthen my clinical skillsets as a practitioner through case interventions and supervision,
- 4) Develop a personal practice regarding the application of play and expressive techniques within a brief service therapy model.

Reflecting on these goals after completing the placement, I feel that I achieved and surpassed my learning objectives as I encountered an incredible amount of knowledge sources to draw from.

I received a substantial amount of professional development through the agency at the time of my placement. I completed four days of Narrative Brief Service Training as well as training and certification in the Child and Youth Mental Health Assessment Form (CHYMH) assessment tool that will be implemented within the agency. I also completed online certification courses in Trauma Focused CBT and Trauma-Focused CBT with Childhood Traumatic Grief through the National Child Traumatic Stress Network. As a personal initiative, I also completed Level One certification in Sandplay Therapy through the Canadian Association of Sandplay Therapists.

As a result of attending to clients with a variety of service needs, I developed a better understanding of organizational structures and services. With this knowledge, I could engage more collaboratively with service users offering them a variety of service options that suited their needs. As lead agency, Keystone works collaboratively with many community agencies through collaborative partnership. Throughout the course of my placement, I developed knowledge and skillsets regarding community partnerships and services that are offered throughout the County. This is particularly useful when working within a large rural community where services can be lacking for more complex client needs. One example of these services is tele-psychiatry. I had

opportunities to present cases as well as observe case consultations with psychiatrists and work with these professionals to develop informed treatment plans for complex cases.

The time of my placement coincided with significant shifts in process and philosophy within the agency. This afforded me unexpected opportunities to observe organizational change processes and become involved within the planning and development conversations. This included joining walk-in clinic and mindfulness meetings as well as sitting in on family engagement sessions with service users. My direct clinical experience along with process observations and reflection provided a rich learning environment that provided insight into my own philosophy as a social worker.

### **Theoretical Lens**

Ecological social work theory is a foundational framework for my clinical practice. Keystone aligns with a systems framework and values interventions with the family as a unit. Ecological and systemic frameworks do contain compatibilities and are complementary to one another (Lehman, 1990). Germain (1972) defined ecology as the science concerned with the adaptive fit of organisms and their environments and with the means that they achieve a dynamic equilibrium and mutuality (p. 16). Thus, the social worker focuses their interventions on the reciprocal interactions and influences of individuals and their environments (Lehman, 1990). Green and McDermott (2010) argue that social work and ecological framework's relationship with explanatory science must be strengthened. If not, their ability to understand and explain how the world really works in the 21<sup>st</sup> century will deem them outdated (Green and McDermott, 2010). As the nature of the profession is already built around understanding problems within an environmental context, the integration of other disciplines sheds light on the underlying processes of ? : "the process of explaining and understanding the world is infinitely more

important than explanations of causality of specific events, as this process gives us capacity to make appropriate, effective and far-sighted decisions about the causal knowledge that traditional science makes accessible” (Green & Mermott, 2010, p. 2416). Thus, social work must engage with important explanatory theories in the natural and social sciences that fundamentally change our understanding of human action within social, economic and ecological systems. An example that is becoming more prevalent is the integration of neuroscience within social work as it helps to explain how environment and person are impacting one another (Wheeler, 2016).

The work of Dr. Dan Siegel has inspired me to introduce elements of neurobiology into my clinical practice and has shifted my focus to a process-oriented approach becoming more attuned to underlying elements such as attachment and mindfulness. This framework has offered a glimpse into the “microclimates” within the complex systems and contexts of individual’s lives (Green and McDermott, 2010, p. 2417). As a result, I feel that my clinical practice is enriched. I will illustrate throughout this thesis document how an enhanced ecological view, processes, and analyses guided and informed my advanced practicum experience.

### **Researcher Reflexivity**

Individuals rely on a combination of analytical and intuitive reasoning within everyday decision-making (Helm, 2016). Within social work, decisions are both high in complexity and uncertainty evoking strong intuitive reasoning (Helm, 2016). Helm (2016) argued that social workers must find a balance between intuitive and analytical forms of reason as analytical reasoning is required for “abstraction, generalization and more defensible decision making (p. 2). Reflexivity within practice and qualitative research can offer analytical processes as it is defined as “the process of a continual internal dialogue and critical self-evaluation of researcher’s positionality as well as active acknowledgement and explicit recognition that this position may

affect research process and outcomes” (Berger, 2015, p. 220). With this definition in mind, social workers can use reflexivity to better understand how they create knowledge and how personal experience, bias, and values affect their interpretations and practices (Berger, 2015; Creswell, 2013). Thus, I felt that engaging in this practice would strengthen my critical analysis of my practicum experience.

Prior to beginning my placement, I was aware of the negative bias I held towards brief service therapy. I acknowledged that I had difficulty understanding how this kind of service could offer long-lasting results for children and families. I am also biased towards expressive therapies that do not rely completely on talk-only techniques. As I have family members that are employed within the children’s mental health services, I am aware that these services are underfunded and running over capacity. I wondered whether the government’s funding model was in the best interest of families or rather created a faster revolving door for services.

As I began to sift through the literature and gained additional knowledge through the professional development opportunities mentioned earlier in this chapter, I was surprised to find numerous similarities between the two approaches. From the research, it appeared that integration of the two approaches was very feasible. But along with investigating how an agency could integrate the approaches, I was also looking to advance my general clinical knowledge and skills in working with children and families.

Once I began my placement, it became apparent that no counsellors but one, was working within a brief service framework. At the time of my placement I was trained along with all Keystone employees in Narrative brief service therapy as they began planning to shift towards a walk-in clinic model of service. Although I did not receive a substantial amount of experience working within a brief service model, I did carry a caseload of eight “clinic” families who I saw

for three sessions or less which helped to inform my critical analysis. Outside of these clinic cases, I offered long term service to families as a member of a team consisting of Ms. Lanktree as well as a Child and Youth Worker. These cases afforded opportunities to offer my skills in play therapy and Theraplay activities in treatment planning.

### **Reflective Practice**

Reflective practice offers a means to gather diverse sources of knowledge thereby allowing practitioners to develop a more holistic understanding of clients (Ruch, 2005). Ruch (2005) describes that holistically reflective practitioners integrate knowledge from all four types of reflective practice “technical-rational, practical, critical and process” (p. 116). This method offers the practitioner a multi-layered lens and challenges a simplified understanding of human behaviour (Hermesen & Embregts, 2015). Holistically reflective practitioners have two defining characteristics; they embrace their practice within the confines of the professional relationship allowing them to embrace each client as unique, and they are less risk averse and adopt creative and innovative strategies with clients (Ruch, 2005). Within the literature, the process in how to actually implement reflective practices is often omitted (Hermesen & Embregts, 2015). The following is my personal attempt to implement this practice in order to achieve a more holistically reflective practice.

As a learner, I would describe myself as curious, questioning and practical. To enrich my learning, critical reflective practice became a daily, integral part of my placement as a student, professional, and individual. There were four ways that I integrated this practice; reflective journaling, mindfulness practice, professional development, and yoga practice.

Within my reflective journal, I would record daily clinical practice, integration of theory, and questions that arose. The reflections were also laden with emotional content regarding my

thoughts and feelings around situations. I could reflect on how my thoughts and emotions affected my choices as a clinician and how I may have reacted differently. This brought to light how countertransference, my values, beliefs and state of mind can impede clinical decision making (Smith, 2016). For example, reading through referral forms prior to sessions could bias how I approach a case based on my past professional experiences, values, theoretical orientation or specialized training. I observed that when reviewing cases with peers that a referral for anxiety or depression would elicit treatment plans in the direction of cognitive behavioural therapy prior to meeting the family. According to Molbak (2012) this is referred to as a “rational/planning” approach to therapy (p. 462). This position assumes that a clearly defined problem yields a rational solution (Molbak, 2012). When I reflected on this, this approach felt like it unconsciously aligned with the clinician assuming the role of expert and did not adhere to a client-centered model. It didn’t feel congruent to my values and I decided to work towards a more client-centered practice. Through readings on related literature, I learned that I could move towards this goal by increasing my self-awareness through mindfulness (Wyatt, 2011; Padilla, 2012). The effect that mindfulness could have on my practice became evident when I was feeling quite ill while working with a family. Although I was sitting in the room with them and making eye contact, my mind was elsewhere distracted by how terrible I felt and wondering how I would make it through the next hour. Although the family did not know I was ill, they were able to attune to my disengagement. Thus, my disengaged thoughts and feelings negatively affected the therapeutic process. Although feeling unwell may negatively impact productivity in any work environment, this experience highlighted the importance of nurturing my own self-awareness. In essence, I discovered that in getting to know myself I am in turn able to give more to my clients.



By reflectively journaling I discovered a lot about myself. To deepen this critical analysis, I had to work within myself. I began attending the morning mindfulness groups offered at Keystone and began attending regular yoga classes within my community to strengthen mind/body awareness. I also attended a Sandplay training as mentioned previously. Within this training, we completed personal sandtrays, reflected on them, wrote stories about the experiences and were afforded a beautiful experience to connect deeply to ourselves. From this experience, I have decided to pursue my own Sandplay process to go even deeper in that connection with myself and develop an understanding of the therapeutic experience similar to what some of my own clients might experience. This process of gaining a deeper understanding of myself was one of the most unexpected learnings but also the most rewarding.

## **Conclusion**

Through the use of reflexivity, reflective practice, supervision and peer support, I was able to enrich the lessons and experiences within my practicum placement. The self-awareness and insight coupled with strong clinical experiences and professional development permitted me to attain and exceed the learning goals I set for myself. This chapter illustrated how my knowledge and skills scaffolded throughout the time of my placement and resulted in a rich learning experience. Through my clinical experiences and peer discussions I began to discern elements of my personal approach to psychotherapy. The next chapter will elaborate with conceptual diagrams, reflections, and descriptions of the process I undertook to acknowledge and develop my therapeutic approach. The chapter will also examine reflections of my practicum experience regarding the compatibility of brief service and expressive play methods.

### **Chapter 3: Critical Analysis of Practicum Experience**

In this chapter, I will be discussing my reflections and critical analysis of my practicum experience. The discussion will be broken down into two sections: (1) The compatibility of expressive play techniques and brief service therapy, and (2) Self-discovery and my conceptualization of the therapeutic process. Each section will highlight the major themes revealed within my reflective practice and demonstrate the growth of my theoretical knowledge and clinical skillsets throughout the practicum process. Within the first section these include application within an agency setting, and observations from practical application with families. The themes within the second section include growth within vulnerability, presence, being, doing, relationship and, lastly, the interaction between these elements.

#### **The Compatibility of Expressive Play Techniques and Brief Service Therapy**

In the early weeks of my practicum, I acknowledged that there would be discrepancies between the realities of the agency at the time of my placement and the learning goals stated within my proposal. My expectations were a clinical environment that had brief therapy practices already embedded within their process. This would allow me to observe these practices and then conceptualize how expressive play techniques may be compatible. Instead, I learned that the agency had chosen to use a narrative brief service approach as opposed to both narrative and solution focused models. The agency was also not using narrative brief service at that time as they were only within the preliminary planning stages. Initially, this stirred a sense of panic as I reflected on the feasibility of my learning goals. However, my learning style of curiosity, questioning and practicality allowed me to view the opportunities present within this detour. On this new path, I was journeying with the staff and agency as they began to implement this new service model, of narrative brief service.

### **Application of Expressive Play Techniques within an Agency Setting**

Throughout the course of my placement, I found opportunities to implement expressive play techniques within the existing model of service delivery. This section will discuss my observations in regards to implementation of these activities generally within the present agency model, and then specifically within a brief service therapy model. The actual materials and activities that were utilized within the placement consisted of computer paper, markers, board games (Jenga, Honeybee Tree, Kerplunk), craft materials (mason jar, glitter), sandtray with a large assortment of figurines (see Appendix C for an example of the sandtray figurine collection used) as well as Theraplay activities (cotton ball hockey, cotton ball find).

Prior to beginning my placement, a worker who worked predominantly with the ages of birth to six years old (B-6) went off on maternity leave. I was assigned her cases and worked collaboratively with two B-6 child and youth care workers (CYW). The opportunity to work alongside the CYWs was a perfect introduction to the organization for me. These practitioners were very knowledgeable in agency process, paperwork, and roles as well as fluent in services offered by community partners. Within the agency, counsellors fulfill a clinical role within the office while CYWs complete most of the hands-on activities and work with the child/youth in the community. The program that is consistently used within the agency by CYWs is the Therapeutic Parenting Program (TPP). A structured 12-week psychoeducational program, this was opportune for me to observe how they were using aspects of play within their work with families.

Although I enjoy working with a B-6 age group, I felt as if I was pigeon holed to this demographic because of my training as a Play Therapy Intern. Through discussions with my peers, I noticed that there was a lack of understanding as to what play therapy is, its

implementation, and what age group it is most applicable with. Some of my peers also had trouble differentiating that I am a social worker with training in play therapy as opposed to being a play therapist. This is consistent with the literature stating that play therapy is typically combined or mistaken for other treatment modalities such as art therapy and expressive arts therapy thereby making the distinction unclear (Shah, 2016). This also presents a problem for play therapy efficacy research (Shah, 2016). To highlight this point, I received an email from the Canadian Association for Child and Play Therapy (CACPT) asking its members to vote on altering the name of the association to omit the word child for the following reasons:

“CACPT is moving away from play therapy being strictly child-focused. Play therapy is being used by play therapy associations and agencies outside of child populations. It also became evident that the broader population of youth and adults might not see themselves as candidates for play therapy due to the child focus” (CACPT, February 2<sup>nd</sup>, 2017, e-mail correspondence).

Upon review of the literature, I found that even the word ‘play’ has not had an agreed upon definition to explain what play is and its role within a child’s emotional development (Hoagland, 2005). Thus, I realized that I had to conceptualize and formulate my definition of my play therapy practice and what that entailed. To my surprise, this took more time and reflection than I initially assumed. I identified that my practice was predominantly situated within a humanistic approach valuing the innate ability of an individual’s potential for self-healing (Angus, Watson, Elliott, Schneider, & Timulak, 2015). However, the approaches that I utilize fall within an eclectic model. This reflective exercise highlighted for me the importance for individuals with play therapy training to be cognizant of their practice approach as well as the

need for increased education and awareness regarding play therapy as well as expressive play techniques within practice.

### **Professional Development**

Consistent with the literature, I observed that only a few of my peers within the agency reluctantly acknowledged that they incorporated some kind expressive play techniques within their practice. As my time within the placement progressed, I noticed that individuals were utilizing some of these practices but through the guidance of a resource. For example, activities from *Creative Interventions for Troubled Children and Youth* by Liana Lowenstein (2015) was a resource that staff utilized when working with children six years old and under. Staff stated that they were uncomfortable incorporating these techniques due to lack of training and understanding regarding applications with children and families, which was reflected in the literature (Sinding, Warren, & Paton, 2014). However, staff who had or were more likely to integrate expressive play techniques could express the value they felt these practices held.

Within the Narrative Brief Service Therapy training I attended while completing my placement, I noticed the importance of professional development for staff. As all staff were completing the training, the environment was conducive to a shared sense of vulnerability. In this type of context, staff exhibited less inhibition in practicing the techniques in front of their peers, discussing their anxieties as well as brainstorming strategies for incorporating these techniques into their practice. After the training concluded, these peer discussions continued as individuals began to implement elements of the training material within their clinical practice. However, as the enthusiasm began to wane, so did peer discussions. I also observed that it was easier for individuals to slip back into their usual patterns of practice that provided a greater sense of safety. Waltman, Frankel, and Wiliston (2016) stated that the three goals of peer consultation:

“(a) refining the therapist’s clinical skills/acumen, (b) ensuring better client care, and (c) providing emotional and practical support for the therapist” (p. 180). Peer consultation appears to be a practice that can help a clinician facilitate the integration of new skills while upholding ethical practice (Waltman et al., 2016). Near the end of my placement, a few peers were working to form a regular peer consultation group. Their intention was to have an opportunity to share experiences in general clinical practice, share resources, consult regarding skills of Narrative therapy and update each other on community resources. The group members stated that they felt a greater sense of support from their peers when they were engaging regularly in peer consultation. Thus, peer consultation could provide the emotional and practical support clinicians feel they require to incorporate expressive play techniques within their practice.

### **Observations from Practical Applications of Brief Service Play Therapy (BSPT) with Families**

This section will highlight the observations from my practical applications of expressive play therapy techniques with families within a general service model as well as a brief service model of three sessions or less. Using reflexivity and reflection, I found that the rationale for incorporating these techniques served several purposes within my practice.

### **Assessment**

Firstly, I found that within the current service delivery model, expressive play techniques could be utilized as an assessment tool. Within the activities, it was possible to get a glimpse of the family when ‘the problem’ was not around. In a more structured game such as Jenga or Kerplunk you can develop a sense of the roles and structure of the family. For example: Who is the leader? Who is engaged? How do members interact with one another? Is there too much or not enough structure for some members? How do members react to winning and losing? How are arguments and disagreements dealt with? There is a rich amount of information that can be

gathered from observing interactions within this context and this use of expressive play techniques has been strongly cited by various authors (Haire, 2009; Hoagland, 2005; Lowenstein, 2015). This fits within a BSPT model as important assessment information can be gathered in a non-traditional therapeutic intervention such as engaging families in creating individual genograms using sandtray figures (for example, animals) (Gil, 2016) (See Appendix D: Genogram with Figures) Genograms portray complex patterns and visually represent elements such as structure of the household, family dynamics over generations, historical trends, and changes in family relationships (Taylor, Clement, & Ledet, 2013). Opportunities also lie in the exploration of themes regarding why individuals chose specific animals to represent their family members and their interactions.

### **Home Activity Assignments**

Secondly, expressive play techniques were used as home activity assignments to be completed by families in between sessions. As a clinician, homework assignments were helpful in regards to time management especially when there was not enough time to integrate an activity within the session. Assigning an expressive play technique as homework served to extend the session into the home and encouraged family members to initiate the activities. This allowed for single or multiple activities to be incorporated into a single session in a way that I felt could strengthen a brief therapy model.

Assigning home activities also permitted me additional time to conceptualize an idea before working with the family to develop the activity. The following is an example of an activity I developed with a family who referred their youth for low self-esteem. The child or youth was to find a box, the size of which was left to their choosing. They decorated it with pictures, words, items, anything that expressed or represented what they loved about themselves.

Each day, at least once, parents were asked to take a piece of paper and write something positive that they observed in their child and describe why they love this child. Parents and child/youth then decided on a day of the week when they would read and discuss the papers together. I observed that when families completed homework assignments designed for and with them, the following session included increased use of self-reflective language in regards to patterns of their communication, interactions, and problem solving. The feedback from the activity listed above was that the family found a way to communicate with each other in a way that was emotional, reflexive, and novel from their usual communication style. The family enjoyed the time they spent each week reading through the notes, reported feeling closer as a family, and were surprised at the enthusiasm their child displayed in response to the activity.

### **Engagement**

Thirdly, expressive play techniques can be used to promote engagement amongst family members. I observed that when families were engaged in a game or fun activity the interaction felt more comfortable and authentic. In many cases families could laugh and enjoy the process together. I found that the play techniques were not limited to a specific age range, however, the techniques had to be compatible with the personality, values, emotional state of the client as well as supported through theoretical knowledge. An example would be a parent who is not playful and feels uncomfortable doing so. I would only incorporate these techniques if I felt they would reinforce my approach or until the therapeutic alliance and relationship were strong enough to develop trust.

Incorporating these techniques also appeared to lower resistance amongst children and youth. Though reflection, I felt that the kind of questions that are asked within the narrative model and the nature of play techniques communicated a strong sense of curiosity and



genuineness to the youth. As a result, I found that my experiences supported the findings of Willis, Walters, and Crane (2014), in that child talk increased based on the amount of time spent in expressive activities. Along with verbally expressing themselves, children and youth were able to: (1) create art and sandtray pictures of richer narratives than could be expressed verbally, and (2) express more abstract ideas by describing the art they had created. By uncovering more alternative means for children/youth to communicate they could express themselves more clearly and effectively with their caregivers. This will be described in detail within the next section.

### **Reassurance for Parents**

One of the most common statements by caregivers was that they had decided to seek out counselling because they felt unsure about how their children were functioning. One of my observations was that by increasing child talk, there was a decrease in parental talk within session. I observed how parents appeared to be experiencing many emotions while actively listening to their child; captivated, surprised, relieved, sad, and happy. Many expressed a sense of relief that their child had the ability to express how they were feeling. In using play techniques there was less reliance on language and more on expression. This would often transfer on to parents who began to use less language in trying to have the child answer why they did something or how they would feel and increase their use of the same techniques such as show me how sad you are or draw me a picture about your day. For some families, they implemented these techniques into their regular communication with their children and felt that they no longer required services.

These concepts were expanded from emotional expression to family engagement in creatively problem solving. Families appeared to enjoy developing creative solutions to problems and children/youth were able to be active participants (Schaefer, 2011). One family and I

conceptualized and developed an expressive tool to help the child express and cope with feelings in school and home environments. The child had final say in all of the elements of the tool including diagram, font size, and structure. The family expressed how they felt this would help them in their abilities to communicate with each other and the child expressed excitement to use the tool they had created (see Appendix E for the Feelings Expression and Coping Tool).

### **Novelty**

An observation that created a connection between narrative and expressive play techniques for me was the use of novelty. Within narrative practice framework, this is a foundational concept as questions are asked to access richer stories to uncover deeper unconscious themes such as value systems (Young, 2016). This process parallels play in much the same way in how play and art externalize the problem and give clues to unconscious material. Within neuroscience, the idea of novelty has been shown to promote new neuronal growth and connections (Siegel, 2006). I had underestimated the strength of this concept as a therapeutic tool. This was particularly evident in my work with parents who taught me how one question has the potential for deep meaning. One parent returned to our second session with their family. After providing me with updates as to how they were doing, the parent told me how one question I had asked their child within the last meeting resonated deeply with them. They spent the last two weeks reflecting on it and had used the question to form insight into themselves. They stated that the patterns within the family were rippling from them. They elaborated on the details of this insight and closed by stating they had decided to pursue their own counselling feeling that this was the key to helping the family and themselves. They didn't tell me what the question was but I listened in amazement at the level of self-exploration this person had undertaken. The family felt that they would like to attend one more appointment as a follow-up

but felt satisfied that they no longer needed to continue service. This was an experience that not only helped me to see some of the value in the brief narrative approach but also made me deeply reflect on what elements within the therapeutic process were necessary to facilitate this kind of client experience. This process will be explored within the next sections.

### **Self- Discovery and My Conceptualization of the Therapeutic Process**

As a student in any profession, hobby, or skill, there is an acute sense of vulnerability that must be embraced within the learning process. For myself, within the placement, the feelings that accompanied this vulnerability were uncomfortable. These feelings had the power to instill self-doubt, anxiety, and an unsureness like walking off a path into the deep woods. Brown (2013) stated that vulnerability is the center of all difficult emotions, but is also the birthplace of every positive emotion. Although this is a universal emotion, there are specific implications for clinicians. By embracing vulnerability in their therapeutic interactions, social workers will not always appear in a good light, nor always seem understanding, wise, or strong (Dion & Gary, 2014). However, sometimes a path of uncertainty can lead to beautiful, undiscovered places. As I reflect on the entire practicum experience, my greatest take-away was that my ability to accept the uncomfortable vulnerability led me to unexpected and rich places within my learning journey. This chapter will illustrate the process I worked through and the lessons taken away.

### **Growth in Vulnerability**

My experiences solidified my belief that social work as a profession is not linear, clean, and does not always follow a pre-determined process. This was highlighted repeatedly if I attempted to control the direction of the session. For example, peers and I would attempt to pre-plan activities (expressive and more traditional approaches, for example, CBT) that we hoped to incorporate into sessions. Typically, there was one of the following results: the family was in a

completely different place and the activity was not applicable at that time; the family engaged in the activity and it had a different result than we expected; or the family was hesitant to engage. In one particular experience, Ms. Lanktree, a CYW, and I organized an activity and implemented it within a family session. Although we felt that the intervention fit within the context of the issue and the family, the activity was completely misaligned in some way with the perceptions of the family.

Within my supervisory discussions with Ms. Lanktree, we discussed with hindsight how our interventions within the sessions could have improved. We disseminated what theoretical knowledge was guiding us in the decisions we made and though our decisions may have fit with the literature, we were unsuccessful. For me, this spoke to the complexity of the human experience and how some interventions present a reductionist intervention. Much like a maze with many entrances, the family and I were beginning the journey in different places towards the same goal.

The reflective discussions with my supervisor also highlighted in an indiscriminate way, the role of the therapeutic process. This presented an aha moment for me. I found myself beginning to visualize the various elements of the therapeutic process within a system. How were the elements interacting and strengthening one another? In regards to the example described above, I hypothesized that the strength of the therapeutic relationship was lacking, causing the family to lack a sense of safety and therapeutic alliance within the therapeutic relationship, and an inability for us as clinicians to achieve congruency. This began the first stage of my conceptualization of my approach to the therapeutic process.

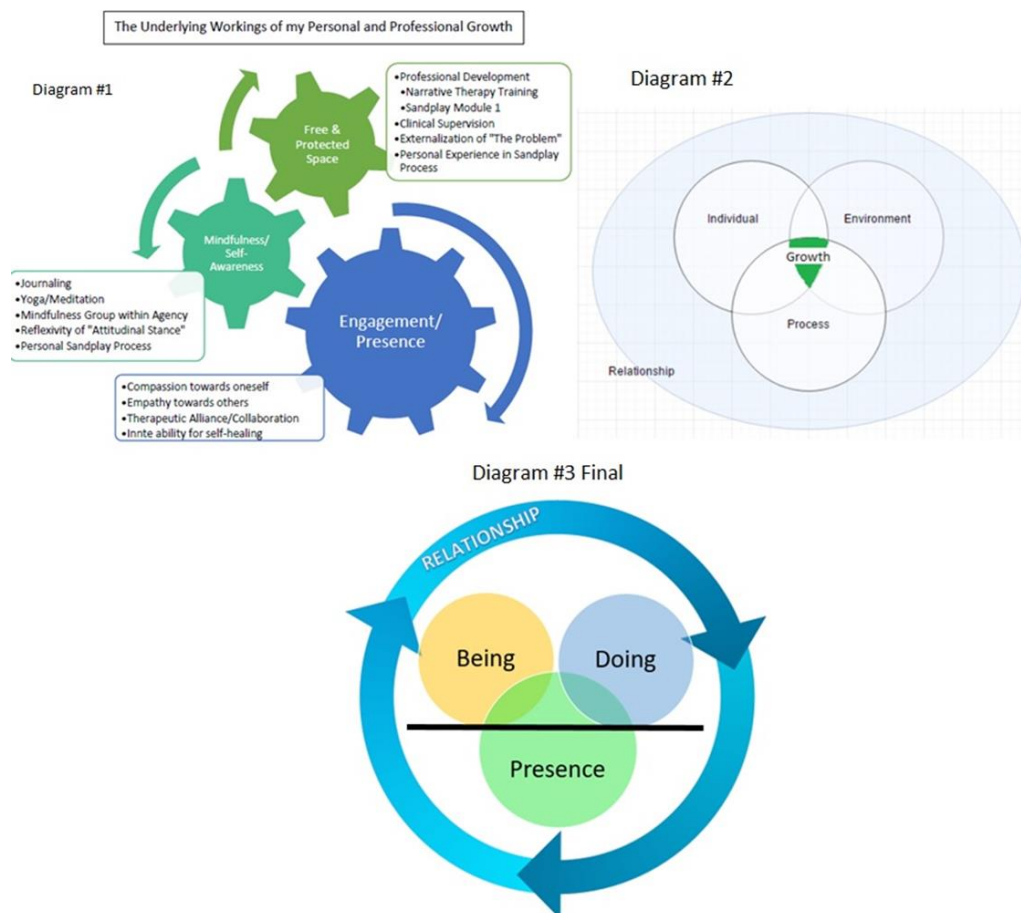
### **My Conceptualization of Elements within the Therapeutic Process**

Throughout my placement, I was continuously engaged in researching the literature relevant to therapeutic processes. For myself, this was crucial to enrich my reflexivity and reflective practice. In developing my model of change, I was heavily influenced by client centered theory (including child-centered play therapy), experiential therapies, interpersonal neuroscience, and narrative practices. Clinical practice, professional development, and an extensive literature review, helped me develop, shape, and evolve my model until I felt it accurately reflected both my practice experience and the literature. The process is highlighted below within Figure 1. The elements I identified within my final model are: Presence, Doing, Being, and Relationship. Once described, I will be elaborating on the interaction of the elements as well as the connection to play therapy and narrative practice in brief service.

### **Presence**

Presence within the therapeutic relationship is an essential ingredient encompassing attunement with individuals and families, the self of the therapist, and with the relationship (Crenshaw & Kenney-Noziska, 2014). A concept within presence is that of therapist authenticity. Authenticity is a powerful foundation for all healing within the therapeutic relationship as it provides an opportunity for “co-regulation of challenging internal states” (Dion & Gray, 2014, p. 56). To achieve this, therapists must be open to their own bodily and emotional states as authenticity requires being present, attuned, and accurately interpreting nonverbal communication (Siegel, 2006). When a therapist allows the client’s emotional state to influence his or her own, he or she can see how these inner shifts can offer insight into the internal world

**Figure 1: Process Model Conceptualization Evolution**



of the client and this is known as countertransference. Objective countertransference describes a therapist's ability to experience both the client and their own emotions from an "observer state of mind" (Dion & Gray, 2014, p. 56). Clinicians risk miscommunication with their clients if they are not authentic and are incapable of interpreting their own internal states (Siegel, 2006). When a therapist combines the nonverbal world of sensation with verbal understanding, he or she is able to create a deep sense of "resonance" that can profoundly influence the client's brain activation in therapy and allow clients to push themselves to be present at the edges of the therapeutic window (Dion & Gray, 2014, p. 58). Over time, this connection within the therapeutic relationship can help to adaptively rewire the brain for self-reflection and self-

regulation (Siegel, 2006). To attain authenticity, Kestly (2016) encouraged the practice of mindfulness, to pay attention in the present moment encouraging self-awareness without holding onto judgment and criticism.

### **Mindfulness**

Mindfulness teaches that emotions are transitory in nature, as such, when we become overwhelmed by strong emotions, being mindful of these emotions gives them less power and our affect tolerance can increase (Padilla, 2011). This tenet of acceptance allows social workers to embrace judgments and feelings without becoming entangled in them (Padilla, 2011). This is a key component for clinicians if they are to help as a container for strong emotions: “enables therapist to better serve as a container for intolerable affect of patient and maintains our ability to access renewable sources of internal refuge” (Padilla, 2011, p.9). When clients can sense that a clinician is not intimidated by their strong emotions they are free to bring their most difficult emotions forward (Padilla, 2011). For a clinician to achieve what Siegel (2016) termed the phrase ‘mindful therapist’ this requires qualities of conscientiousness, open-creative, and non-judgmental consciousness, all of which can be cultivated within mindfulness practice (p. 23).

Graduate programs in social work focus on clinical and theoretical aspects but a student’s ability to be warm, compassionate and empathize with others is only nurtured through clinical experience (Padilla, 2011). Mindfulness may be the only way to enhance these qualities within an individual: “Empathy towards others is the natural extension of the compassion towards oneself cultivated in mindful practice” (Padilla, 2011, p. 7). Mindfulness amongst therapists improves not only their levels of self-efficacy, empathy and ability to direct attention but also helped to develop global counselling skills such as a therapeutic relationship, tolerating affect, sessions management, and appropriate self-disclosure (Jooste, Kruger, Steyn, & Edwards, 2015).

Studies have also emphasized the importance of mindfulness within a supervisory relationship. Higher levels of supervisor mindfulness could encourage the supervisee to explore clinical work and self-awareness in greater depth (Wyatt, 2011).

I was particularly interested in understanding the effects of supervisory mindfulness for supervisees. Within my placement environment, it was apparent that supervisors had a significant number of roles and responsibilities above and beyond managing staff and performance. This was especially true within the timeframe of my placement as there were several large projects coinciding at the same time. In addition, a substantial amount of data reporting is required to fulfill Ministry standards. Competing demands on the supervisors meant it was difficult to offer supervisees frequent, uninterrupted supervision sessions. Demands such as data reporting could consume half to full supervisory sessions leaving little to no time for case discussions. The supervisors were able to identify that this was an issue and were making an ongoing conscious effort to remedy this.

One of the most interesting aspects I discovered in regards to mindfulness was its relation to attachment. As clinicians, we serve as secure attachment figures to our patients. Siegel (2016) stated that if we were unable to form secure attachment to our caregivers as infants, there is still opportunity to do so as adults. Using mindfulness and self-attunement, we create new neural connections that are similar to those of a secure attachment (Siegel, 2016). Although I had the opportunity to learn a great deal about the benefits of mindfulness practice with my MSW coursework, I was unaware of its potential for such powerful neural integration.

The applications of this concept as I observed within my placement seemed to apply a reductionist understanding and application. Within my placement environment I observed that mindfulness appeared to be a trendy clinical intervention. The mindfulness interventions that



clinicians incorporated within their practice were related to mindful breathing and guided meditation using an application on their phones. Some of the staff were divided in their willingness to learn more about mindfulness and some were highly resistant based on religious ideologies. In a survey completed by staff, only a small staff incorporated mindfulness practices within their daily life, and the majority identified that they had little knowledge on the subject but were interested in learning more. I believe that if staff had a more comprehensive understanding of the benefits of mindfulness practice in regards to self-attunement, relationship building, empathy, and supervisory outcomes, the practical applications could present an expanse of possibility for individuals at all levels of the agency.

## **Being**

This element is based around the tenets of client-centered theory empathy, genuineness, and warmth (Schottelkorb, Swan, Garcia, Gale & Brooks, 2014). Being is not possible without presence so the two are interwoven. An individual's personality traits may be just as important as other factors in predicting treatment outcomes. These qualities of warmth and empathy are shown to have positive effects on treatment outcome (Padilla, 2011). One of the areas that has the most impact on the therapeutic relationship is empathy. A meta-analysis of 45 studies related to empathy-outcome yielded a median size of .32 constituting the highest effect size in the therapeutic relationship (Norcross, 2005, p.17). But, to be truly empathic, you must allow yourself to step into the feeling with the other individual, a vulnerable act for any individual. Brown (2013) stated that without vulnerability there is no opportunity to experience empathy. When we are empathic we can achieve what client-centered theory defines as congruence: "When the feelings the therapist is experiencing are available to his awareness, and is able to live these feelings, be them and able to communicate them if appropriate" (Schottelkorb et al., 2014,

p. 2). I envisioned ‘being’ as encompassing elements that contribute to the therapeutic environment. This includes elements such as the personality characteristics of the clinician, the qualities mentioned previously of empathy, genuineness, and warmth.

## **Doing**

‘Doing’ represents the therapeutic alliance and collaboration that works in concert with the intervention that is being utilized within treatment. ‘Doing’ emerges from presence and is grounded in clear theoretical and research foundations (Crenshaw & Noziska, 2014). Empirical evidence supports that there is a strong relationship between working alliance and a positive therapeutic outcome (Wyatt, 2011). Crenshaw and Noziska (2014) warned that social workers must not only rely on elements of the therapeutic relationship but base their interventions in theoretical foundations as opposed to a toolbox of assorted techniques. The relationship and interventions then find a balance of being based in empirical evidence but tailored to the unique needs of the individual. Norcross (2011) highlighted this by stating that the matching the ‘directiveness of the therapist’ to the client improved treatment outcomes in 80% of studies (p.23). For example, high-resistance clients benefit from minimal therapist directives and the opposite is true for low-resistance clients (Norcross, 2011).

Within practice, it is difficult to differentiate personality characteristics and how these impact your practice without reflexivity. I had the opportunity to engage in several discussions with peers identifying how our personality characteristics influenced the interventions and approaches that we used within sessions. The conversations we had were interesting and provided some thoughtful points to consider. One of these points was in regard to the directiveness of the therapist as discussed above. Some peers identified that their approach was predominantly directive with clients. Through reflection, they identified that they felt a non-

directive approach created more space for silence and unknowns, instilling feelings of discomfort and anxiety. Thus, by being more directive, they allowed less space for their own feelings of vulnerability. Based on the knowledge and experiences I have regarding non-directive practice, we engaged in discussions identifying when a directive versus a non-directive approach might be more appropriate for a client. Ms. Lanktree would identify as a more directive practitioner while I would identify as aligning with a more non-directive approach. From observing her sessions, I was attentive to the instances when a more directive approach was appropriate to the client needs. In one occasion, I had invited a teenage client of hers to create a sandtray. Ms. Lanktree was invited to observe my session along with the teen's mother. As the mother appeared to be comfortable in the environment, I invited her to also create a sandtray in a second tray beside her child. The session was predominantly silent while the two participants created their trays. I lead the verbal exploration of the trays. After the session had ended, Ms. Lanktree discussed how she struggled at the beginning of the session to remain silent and be present in observation but became more comfortable as the session progressed. The trays created by the participants were rich in symbolism that could inform her clinical wonderings about what was occurring for this client. This highlighted, I believe for both of us, that a balance between therapeutic directness can enrich a therapeutic intervention if based on the needs of the client in that moment. To illustrate a completed sandtray picture please refer to Appendix D (a Sandtray completed by myself within Sandplay training).

Alliance is not the same as therapeutic relationship, rather it is the result of nurturing elements that create a safe environment. (Horvath, Del Re, Fluckigier & Symonds, 2011)

Alliance cannot be separated from the interventions but is influenced and essential to all parts of therapy (Horvath et al., 2011).

## **Relationship**

The common thread that I observed within all of the interactions I experienced within my placement was the importance of relationship. As a student, positive relationships with peers and supervisors were elements that helped me to embrace my vulnerability as an opportune learning experience. Siegel (2016) stated that relationships are at the core of all our interactions and it is through them that we come to know the world. My process model highlights this by stating that relationship is present within all levels of therapist interaction whether that be with themselves, the client, family, or community. This is clearly stated by Henry (1998):

“as a general trend across studies, the largest chunk of outcome variance not attributable to pre-existing patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist regardless of technique or school of therapy” (p. 128).

Relationship was conceptualized within my process model as an inclusive and integral element within all interactions. This does not exclude elements of evidence-based practice. The inclusion of relationship strengthens the theoretical rationale of incorporating the chosen interventions and could strengthen the outcome of the intervention (Norcross, 2011; Molbak, 2012). Within my clinical encounters all interventions were contained within a sense of relationship. I reflected that when the elements of ‘presence, doing and being’ were weak, the relationship that serves to contain these elements was also weak, and I noticed a correlation between treatment outcome. This was exemplified in the example of the failed intervention from page 11 within the section on Growth in Vulnerability.

## **Interactions Between Elements**

The interactions of these principles are based heavily within a humanistic approach to

therapy. 'Presence' is considered one of the primary elements from which all others are derived. This is supported by research that has demonstrated a significant relationship between counselor mindfulness and client perceptions of therapeutic relationship and working alliance (Wyatt, 2011). Thus, this has been placed as the foundation of the all other elements within the process.

Within the process model in Figure 1, there is a call for balance between 'being' and 'doing'. This reflects research on common factors within psychotherapy that emphasize a stronger emphasis on the quality of the therapeutic relationship rather than a specific approach or technique (Crenshaw & Noziska, 2014, p. 35) In humanistic theory, 'being' is primary and guides the therapy while 'doing' is secondary and derives from 'being' (Crenshaw & Noziska, 2014) 'Being' and 'doing' are of intrinsic value especially in cases when doing emerges from being (Crenshaw & Noziska, 2014). This is also consistent with the lack of evidence for specific treatment effects bolstering the argument that almost all the effects of psychotherapy are due to factors common to all psychotherapies (Norcross, 2011).

The process model in Figure 1 and the interaction between the elements reflects how I conceptualized my clinical experiences. For example, when I had opportunities to observe sessions, it was apparent when the clinician and client were not attuned to each other. This was apparent to me as the child/youth reacted with resistance, disinterest or appeared to not understand the questions being asked. This appeared to negatively impact the level of engagement and congruence resulting in an intervention that I perceived as not quite the right fit. The model, research, and clinical observations helped me to visualize different elements of the therapeutic process and structure my approach to fit the needs of the client. This is much easier said than done for Figure 2 illustrates that the therapeutic process is complex, partially unexplained, and subjective based on the client's experiences? This information encouraged me

to develop a deeper understanding of how my personality, values, and temperament influenced my practice through reflective and reflexive practice.

### **Relationship of the Process Model to Play Therapy and Narrative Therapy**

Although I found a lot of information regarding the elements that are present within the therapeutic process, I still felt reluctant to acknowledge the value of brief service therapy. I came across some interesting studies that gave me a better understanding of the underlying processes. I found several studies that highlighted the predominant narrative patterns between good vs. poor outcome therapy (Angus, Hardtke, & Levitt, 1993; Angus, Levitt, & Hardtke, 1999; Hardtke, 1996; Jackson, 1993; Levitt & Angus, 1999). The studies highlighted three predominant forms of personal narrative: (1) external narrative modes – these provide a detailed description of an event and answer a “What Happened?” question; (2) internal narrative modes – describing and elaborating on emotions and reactions connected with an event and answer a “What was felt?” question; and (3) reflexive narrative mode – involves a reflexive analysis of events and/or emotions and answers the question “What does it mean?” (Lewin, 2010, p.19-20). Lewin (2010) described that productive therapy uses reflexive analysis more frequently to help transform new perspectives and meaning.

Lewin (2010) found that experiencing activities found within experiential therapies (role-playing, use of figure, expressive play techniques) and developing alliance were moderately to highly correlated suggesting that alliance and experiencing are interrelated (Johnson, 2009; Lubimiv, G., personal communication, March, 17, 2017). Banhan and Schweitzer (2015) found that clients entering psychotherapy engaged in less amounts of reflexive narrative with clinicians. Clinicians with best outcomes engaged in more reflexive narrative by the end of therapy as opposed to poorer outcomes therapy that continued to engage in predominantly

external conversations (Banham & Schweitzer, 2015). They suggested that reflexive conversations are emerging as a possible predictive factor for therapeutic outcome (Banham & Schweitzer, 2016). The ability of a clinician to engage their clients in an internal narrative interaction may be the bridge to their development of a more reflexive understanding. This is achieved through the clinician's use of observational language highlighting how by attuning to a client the clinician provides the safety for them to reflect deeper:

“A therapist's ability to give a voice to what they have observed about the client's experiences, beliefs, motivations and desires helps their client to further elaborate and develop new understanding about what it means to have experienced particular emotions in response to particular events” (Banham & Schweitzer, 2016, p.11).

For myself, this literature highlights the connection between play techniques and narrative brief service therapy. The practices within narrative therapy embrace and build on the processes that are necessary to access the internal and reflexive narratives. Examples of these practices include witnessing, scaffolding the conversation, and having the clinician listen for double storylines (Lundby, 2014). The recommended posture of the clinician within the narrative session is congruent with client-centered expressive play techniques as well as accessing internal narratives. A therapeutic stance of curiosity, collaboration, transparency, non-expert stance and seeing the individual as capable of innate self-healing are essential within this approach (Young, 2016). Language present in non-directive expressive play techniques could potentially strengthen this narrative approach as it incorporates frequent observational language (Axline, 1993). This research strengthened my ability to perceive the similarities of the two approaches and their compatibility within practice.

This research on narrative processes could possibly give explanation to my observation that expressive play techniques reassured parents as to their child's functioning and resilience. Parents would discuss their inability to access the deeper and richer narratives from the child. They would give examples such as when the child comes home from school and gives a one-word 'fine' when asked about their day. The parents would then receive a call from the school describing that the child had struggled that day. The literature defined narratives such as 'fine' or a description of what happened during the day as the 'external narrative' which is void of emotional content (Lewin, 2010). Reflecting on this further, I wondered how the cognitive development of the child influenced their ability to access the reflexive narrative verbally. What we know from the literature is that expressive play techniques tap into the symbolic unconscious (Haire, 2009; Schaefer & Athens, 2011). For example, the rationale for creating the tool in Appendix E (feelings expression and coping tool) with the family was that the child was having a difficult time verbally describing how they were functioning at school. When I met with the family and asked the child to instead draw what it was like at school, they were able to communicate in a way that was emotionally laden, symbolic, and provided a more accurate account of how the child was interpreting and experiencing the event. I also had some success when I coupled aspects of expressive play techniques (such as drawing) with narrative techniques (externalizing the problem). Another example was a child referred for anxiety where the problem was externalized as 'the worry.' When drawn, 'the worry' was a balloon that the child was holding onto with a string, getting ready to blow it away. This child identified that being able to write/draw 'the worries' and have their caregivers read them out loud, made them grow very small. The family then came up with the idea together that a worry box would be made and worries would be read on a designated day. Within my practice applications, each



technique appeared to strengthen one another. As a result, when the child was able to communicate more effectively it was easier for myself as well as the parents to align the intervention to the needs of the child.

## **Conclusion**

As funding dollars remain consistent while client numbers increase, the current system creates pressure for quicker therapeutic results (Lubimiv, G. in conversation March 14<sup>th</sup>, 2017). The consequences are greater emphasis on the tools of the trade as opposed to common factors such as therapeutic presence and quality of therapeutic relationship (Crenshaw and Kenney-Noziska, 2014). However, Norcross (2011) argued that evidence based practices that omit the importance of relationship are incomplete and potentially misleading. This is due to evidence based practice failing to acknowledge who the therapist is as an individual and the non-diagnostic characteristic of the client that influence the therapeutic relationship (Norcross, 2005). The potential solution is erasing the dichotomy that differentiates treatment and relationship. The therapy relationship does not stand on its own, rather it interacts with a number of other variables: discrete interventions, patient characteristics, and clinician qualities in determining treatment effectiveness (Norcross, 2011; Solt, 2003; Kestly, 2016). More examples of the combination of evidence-based practice and relational interventions are becoming present such as trauma focused cognitive behavioural therapy (Molbak, 2012). Adapting or tailoring the therapy relationship to patient characteristics in addition to diagnosis enhances the effectiveness of treatment. Practice and treatment guidelines should address therapist behaviours and quality that promote the therapy relationship. I attempted to highlight the importance of this concept within my model by illustrating a balance between ‘being’ and ‘doing.’

This chapter highlighted how I nurtured a depth and understanding of my clinical practice within a humanistic perspective. I began by exploring what it meant to embrace vulnerability and how this could translate both personally and professionally. I then used research to go deeper into the themes, observations, and questions present within my reflective and reflexive practices. I learned that the therapeutic encounter is complex, mysterious, and multi-faceted. Through attunement to myself as a clinician and the needs of the client/family, I can strive to present an intervention tailored to their unique needs. The next chapter will highlight how the analysis presents implications for social work practice generally as well as my personal development as a clinician and individual.

## **Chapter 4 - Conclusion**

To fulfill partial requirements for the Laurentian University, Master of Social Work program, I completed the Advanced Practicum (SWRK 6024) from September 12<sup>th</sup>, 2016 to February 8<sup>th</sup>, 2017. The practicum was completed at Keystone Child Youth and Family Services, a children's mental health agency serving Grey and Bruce Counties. My goals were to enhance and strengthen my clinical skillsets working with children and families in a community agency environment within an ecological perspective. Specifically, I sought to develop a personal practice regarding the application of expressive play techniques within a brief service therapy model.

Throughout the duration of my placement most of my experiences consisted of direct service with children/youth and families within clinic and ongoing services. Additional opportunities such as case presentations in tele-psychiatry, case conferencing with community collaterals, and attendance at agency planning meetings were also provided. Experiences within service, community, agency as well as ample professional development opportunities provided exposure to the multi-disciplinary environment that a community agency must operate within.

As mentioned previously, the placement environment offered less opportunities to observe brief therapy practice. Consequently, through reflective/reflexive practice, clinical experiences and professional development, I explored underlying processes of the therapeutic relationship that related to my therapeutic stance as a practitioner and the commonalities these shared with brief and play models. This chapter will summarize my conclusions in regards to how my therapeutic stance relates to brief service play techniques, and social work implications.

### **Therapeutic Stance and Brief Service Play Techniques**

One of my learning goals in pursuing a placement was to develop a personal practice in regards to expressive play techniques within a brief service model. Throughout the course of the placement I incorporated expressive play techniques such as art, sandtray, board games and Theraplay activities. Through experiences with families, I observed several specific applications of expressive play techniques in clinical practice. These observed applications included assessment (Haire, 2009; Hoagland, 2005; Lowenstein, 2015), home activity assignments, promoting engagement of family members (Willis Walters, and Crane, 2014; Schaefer, 2011), providing reassurance for parents, and utilizing the concept of novelty (Young, 2016; Siegel, 2006). As Keystone serves individuals and families 0-18 years old, I felt that these practices were developmentally appropriate and served to strengthen the tenets of a narrative brief service approach.

As outlined within my various clinical examples, many of the families were open to engaging in a creative, collaborative process. The incorporation of expressive play techniques allowed the child/youth to direct the creation of the activity as well as how they would like it incorporated within the home. This was exemplified during an activity that was created with a youth who was hesitant to verbally express when they were feeling emotionally distressed or anxious. The youth and their parents coloured a hockey stick blue on one side and red on the other. The hockey stick was to remain on the fridge and when the youth flipped it from blue to red, the parent would know to go to the youth to provide emotional support.

Expressive play techniques such as sandtray, allowed individuals to create complex, rich narratives without being limited to verbal expression. One of the examples stated previously was the teen who created a sandtray that depicted a narrative that was richer and more complex than could be communicated verbally. The sandtray allowed the teen to communicate through

symbolism some of the internal struggles that were occurring as well visually expressing the progress that had been made and goals for the future. Expressive play techniques offer the clinician a window into the world of the client and allow them to give a voice to their experiences (Banham & Schweitzer, 2016).

Although the literature does not provide strong empirical evidence for brief service, the tenets of both brief service and expressive play models draw on the same underlying philosophies (Bond et al., 2013). Client-centered theory, a humanistic approach to psychotherapy, is at the core of my therapeutic stance. Narrative therapy is also considered a humanistic approach; thus, it aligns closely with the tenets of my expressive play approach and overall therapeutic stance (SAMHSA, 1999). Uncovering strong philosophical commonalities between narrative brief service and client centered theory helped to minimize my bias towards the idea of brief service therapy. My bias stemmed from lack of understanding that you could provide a service in a shorter amount of time but in a way that was collaborative, client-centered, and reflexive. Prior to my placement, brief therapy and client-centered practice appeared completely contradictory in my mind.

My practicum provided knowledge attained only through experiential learning that served to inform and strengthen my theoretical foundations. Firstly, I developed an understanding of the importance of a holistic social work practice. A recurring theme throughout the literature reviews, professional development and reflexive practice, was that of balance. This was illustrated in several forms. Within my personal process diagram (see Figure 1 on pg. 51) this was depicted as the balance between the aspects of ‘being’ and ‘doing’ (Crenshaw & Noziska, 2014), highlighting the importance of the clinician being present with the client and nurturing therapeutic alliance to strengthen collaborative therapeutic interventions (Horvath et al., 2011).

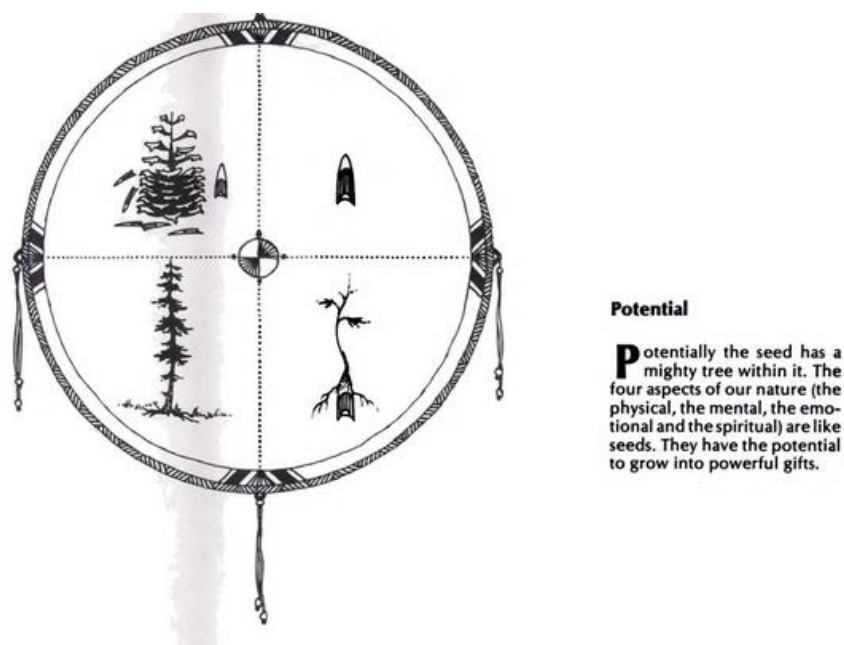
Within the literature, scholars called for erasing the dichotomy between treatment and relationship, and finding a balance between the two perspectives for informed treatment applications (Norcross, 2011; Solt, 2003; Kestly, 2016). Within reflexive practice, balance is a key component to achieve holistic reflective practice which balances four elements of knowledge: “technical-rational, practical, critical and process” (Ruch, 2005, p. 116). As a great deal of my previous clinical experience has been working with First Nations populations, I am drawn to the medicine wheel to conceptualize this concept of balance and holism (see Figure 2 below).

The medicine wheel is a symbol used to help understand concepts and ideas that we cannot physically see. It expresses relationships between four elements, in this case, mental, physical, emotional, and spiritual (Hart, 2002). Each of these elements are part of a whole and understanding one part of the wheel is connected to understanding all other parts (Lane, Bopp, Bopp, Brown, 1984). Although balance can be achieved periodically it is never achieved for an infinite amount of time; it is constantly pursued (Hart, 2002). For social workers, I believe this is a powerful lesson as it offers insight into the constantly evolving and fluctuating systems of our profession.

This lesson was experienced through nurturing my personal mindfulness practice. Through mindfulness morning groups, guided mindfulness meditation, yoga, and journaling, I worked towards nurturing my own abilities for self-awareness. As my capacity increased incrementally, I realized that mindfulness, for myself, was an integrative ingredient, connecting and communicating with all other elements of my being (physical, emotional, spiritual, mental). I became aware of the positive impact it offered for various areas of my functioning. Within sessions, I could offer more attention and presence to my clients. When I could sense feelings of

anxiety arising, especially when I was meeting a client for the first time, these feelings had less control over my thoughts, reactions and behaviours. I believe that these qualities stemming from my personal mindfulness practice directly benefitted the services my clients received. Although my placement has concluded, I will continue to nurture my mindfulness practice as I felt it directly benefitted my qualities as a clinician and individual and directed me towards a more holistic approach.

Figure 2: Balance within the medicine wheel for growth (Lane et al., 1984, p. 13)



Secondly, experiential learning strengthened my belief that no approach in psychotherapy is a one size fits all. For example, although I strongly affirm the value of expressive play techniques, these interventions are not effective interventions for all individuals. These methods of interventions are also not congruent with all clinicians as I learned of the importance of a clinician's personality characteristics. For clinicians to embrace any kind of expressive method they must value imagination, feeling, experience, and intuition (Coholic, 2012). Play therapy students for example displayed a statistically significant higher regard for children than non-play

therapists (Solt, 2003). Many of my peers described their preference for working with teens as opposed to young children. It would be interesting to determine if this is a preference based in experience, values or personality characteristics. Once again, I am drawn to the concept of balance, that is, that there are many elements within the therapeutic relationship that must be balanced. Individuals and clinicians are unique in their characteristics but also in the way they interact with one another. Thus, neither fit into a tidy box of one method of service delivery.

Last, I came to understand the importance of a supportive work environment and collaborative team of peers. My practicum experience would not have been as successful without the incredible people I was fortunate to work alongside. My peers and supervisors made me feel welcomed within their workplace and valued the skills that I brought to the practicum environment. There were few times that I felt like a student and not an equal peer. From the onset, my peers asked for my input, were open in their feedback, offered many opportunities for interesting clinical experiences and always made time to answer all of my questions. The relationships with my peers were the key to helping me embrace my vulnerability and be truly open to a breadth of experiences and lessons to be learned.

### **Implications for Social Work Practice**

One of the issues that was highlighted was the importance of clinician supports within an agency setting in the form of supervision, ongoing professional development, and peer to peer learning. It was evident that resources were stretched and social workers had less access to regular clinical supervision. Clinicians within my placement were creative in the means for which they sought out alternative forms of supervision. For example, a group of peers had begun to schedule regular meetings for peer to peer discussion regarding resource sharing and case consultation. Tele-psychiatry case conferences with a variety of mental health professionals



(psychiatry, psychologists, social workers, individuals with specialized training) was a means of securing supervisory input for treatment planning.

This aspect of supervision would also be a crucial element for individuals to begin to integrate expressive play techniques within their practice. I found that clinicians were ambivalent to acknowledge their use of expressive play techniques within their practice which was synonymous with the literature (Sinding, Warren, & Paton, 2014). They felt that they were not qualified to do so due to lack of training. I observed through my placement that staff were more open to using resources that provided direction in how to incorporate these activities. This demonstrated to me that there was a genuine interest in incorporating expressive play techniques if direction and instruction were provided. Peer discussion and learning as well as supervision could be key supports required by staff to begin incorporating these techniques into their practice (Sanders, 2013). For example, within the peer-to-peer discussion groups, individuals could present an activity they developed, discuss the response of the family, and circulate the activity among other staff for their own use.

One future implication for the social work profession regards graduate social work education. Currently, there is a lack of curriculum directed towards nurturing qualities of compassion and empathy within future clinicians (Padilla, 2011). As opposed to nurturing these qualities over time through clinical experience, Padilla (2011) found that one of the ways to cultivate these qualities is through the use of mindfulness practice. The shift towards creating a balance between treatment and relationship could begin earlier within social work curriculum, possibly allowing a smoother transition into practice.

Last, I have come to acknowledge the potential value of a narrative brief service approach. However, I do not believe that this is appropriate as a blanket approach within

community mental health agencies. As stated previously, there is no one size fits all within service for client or clinician. My bias towards brief service was I felt it sacrificed relationship for quicker outcome. If community agencies can find a working balance between treatment and relationship, there stands to be less sacrifice in the quality of services provided. Methods such as expressive play techniques were found, within my experiences, to serve several roles and functions that strengthened the tenets of the narrative brief service approach while also maintaining a strong focus on relationship.

Throughout my advanced practicum experience, I have developed advanced knowledge and skills in clinical interventions within an agency setting. Unexpectedly, the greatest take away lessons are those that I learned about myself as an individual and a clinician. The MSW experience has nurtured my curiosity and love for learning. But it feels as if I am only at the beginning of my journey with a life full of lessons awaiting me.

Grant me the serenity to accept the things I cannot change; courage to change the things I can; and the wisdom to know the difference.

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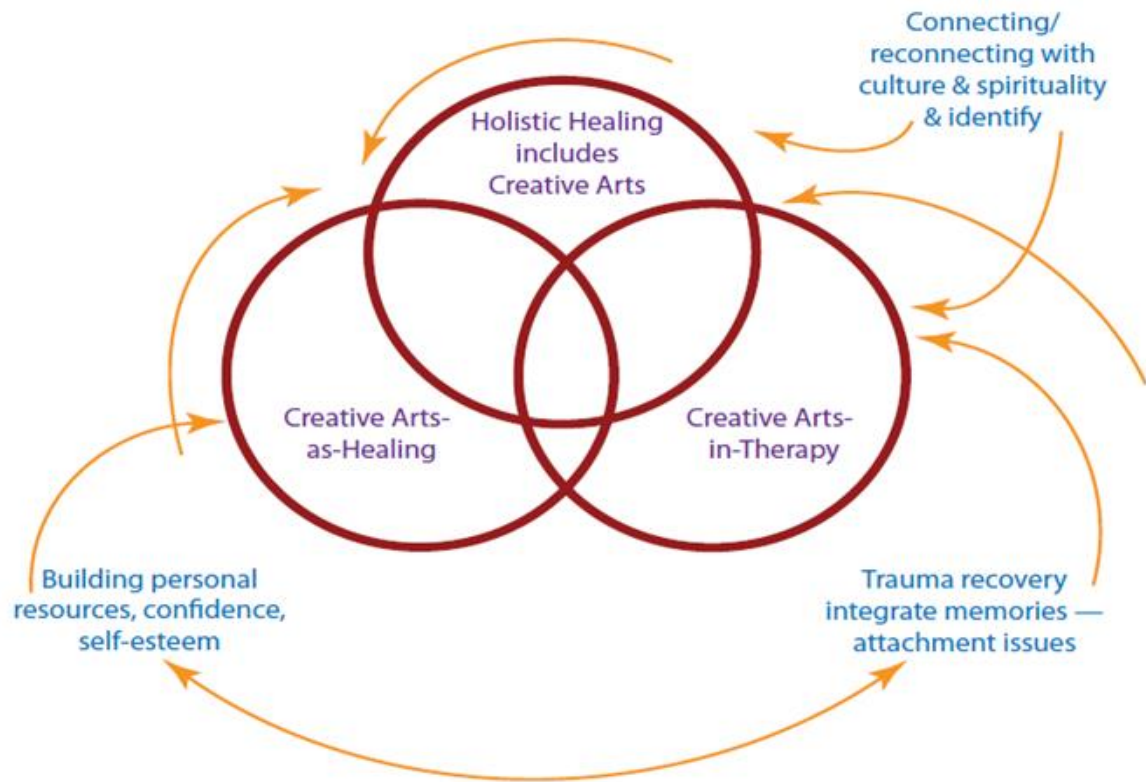
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**Appendix B: Creative Arts and Healing: Three Interconnected Models (Archibald & Dewar, 2012)**

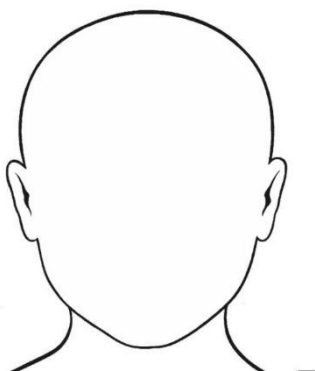






Appendix D: Genogram with Figures ([www.creativesocialworker.com](http://www.creativesocialworker.com), 2014)



**Appendix E: Feelings Expression and Coping Tool****Draw what happened:****This is how I feel:**

This feeling is called \_\_\_\_\_

**Circle what I will do to feel better:**

Draw a picture

Shake Glitter Jar

Mindful Breathing

Go for a walk

Wall push

Hug

Talk to Mom or Dad

**Did this help me feel better:**

YES

NO

**Appendix F: A sandtray completed by myself within Sandplay training**

